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OPEN PERINEAL PROSTATECTOMY.

J. T. AXTELL, M. D., Newton, Kansas.
President Kansas Medical Society.

Read before the Golden Belt Medical Society at Herrington, Kansas, Oct. 5, 1911.

An enlarged prostate does not in itself call for an operation. Many such patients live comfortably for years and die from other causes. When the symptoms of frequency, burning pain and tenesmus occur, especially if associated with residual urine, interference is demanded. This should be done before the secondary symptoms of loss of appetite, strength and weight appear, which are the result of auto intoxication from absorption of retained urine. The same symptoms and even more pronounced come from renal insufficiency, and a patient with renal insufficiency is a poor subject for operation until he has been treated for a time and a free flow of fairly normal urine secured. The mortality in prostatectomy is from suppression of urine. The patient usually presents himself with retention which has probably been coming on for some time and his kidneys have accomodated themselves to this pressure and if the pressure is suddenly removed by the use of a catheter for the first time, you may cause acute congestion and suppression, especially in a partially disabled kidney. A gradual withdrawal of the urine in such cases is safer than a complete emptying and keeping empty of the bladder. Where you are unable to pass any kind of catheter, you have the alternative of an emergency operation or what is probably much safer using a trocar above the pubes and introducing a self retaining catheter. The patient is then ready for treatment to get his kidneys in proper condition for operation. Large quantities of water should be given, rectal injections of normal saline and urotropin by mouth or rectum.

When the quantity of urine and its specific gravity shows fairly well, it is safe to operate.

A great number of different methods of doing a certain operation usually indicates that all are somewhat unsatisfactory. This is probably true of prostatectomy although enthusiastic advocates may be found for several well known methods. The suprapubic route is popular with many operators and gives brilliant results in very many cases. That it is somewhat blindly done, that the urethra is usually entered and torn out on each side, that hemorrhage is not easily controlled and the drainage is necessarily imperfect, are its principal disadvantages. The perineal route has always had more followers, probably largely on account of the drainage. Many of these methods penetrate the bulb of the urethra tearing the urethra out first on one side and then on the other in the prostatic portion, usually tearing out and destroying the ejaculatory ducts. The operation is done blindly, by touch alone, and while the best results are often obtained, it makes one wish for a method where he could see just what he was doing in order to avoid injuring structures further than is necessary. A more extended investigation of the bladder is also desirable in a large per cent of the cases, and this is more easily done in the open method. It would seem, especially for a beginner, that to see every step of the operation is safer and more satisfactory. To save the ejaculatory ducts, which can be done in the open operation, is worth something to some patients.

Potency and sterility however, should not be confounded. Most men of the prostatic age are satisfied if potent only, and care little about sterility which would certainly be caused by tearing out the ejaculatory ducts.

The operation described here is similar to the one performed by Young of Baltimore. The patient is placed with his hips elevated for operation. This allows the rectum to draw back and be more out of the way. A medium sized sound is passed about half way through the membraneous urethra for a guide. A half moon incision is made from two inches on one side of the rectum toward the scrotum and back to two inches from the rectum on the opposite side. This is made through the skin, fat and sub-cutaneous fascia, and the flap is turned back over the anus. With the finger or a blunt dissector the triangles on each side are opened up, as far as the triangular ligament. When this is thoroughly opened up, a bifid retractor is introduced and with a downward traction, the central tendon and muscle are brought plainly into view and divided close to the bulb of the urethra. Another but smaller

bifid retractor is then placed in the upper part of the opening over the urethra and the recto-urethralis muscle fibres are divided in the same way. Care must be taken not to injure the rectum but as the parts are all well exposed, this is not difficult to do. When the urethra is thoroughly brought into view it is opened on the sound, the edges of the wound caught with forceps and as the sound is withdrawn another one is inserted in the wound and passed into the bladder. A dilator may be used to further open the urethra, if needed. A Young's prostatic tractor is then passed into the bladder and opened. By traction, the prostate, if well uncovered, may be brought well up into the wound in plain view and easy reach. Narrow lateral retractors are of use in exposing the parts to view and the muscles are drawn to each side. An incision is made into the prostate on each side of the urethra, parallel with the urethra, and the ejacualatory ducts which are left between the incisions, undisturbed. With a blunt dissector, each lateral lobe is separated from its capsule, the enucleation being finished with the finger. Often blunt curved scissors and even a sharp curette are needed to complete the dissection. The middle lobe may be brought out through one of these openings and shelled or dissected out. The bladder should be exposed with the finger after all the glands are removed, and the tractor withdrawn. Two drainage tubes should be stitched together and inserted into the bladder and irrigation begun before the patient leaves the table. The lateral cavities from which the glands have been removed, are packed with gauze which may be removed in twenty-four hours. The levator ani muscles are then drawn together and stitched with chromic catgut, which restores them to their normal position and gives the rectum support. The gauze strips and drainage tubes are placed together in one lower angle of the wound and the remainder of the flap is stitched with interrupted stitches of silk-worm gut. Normal saline by submammary infusion or by rectum or both, is the best preventative of shock and suppression of urine. Most of these patients are feeble, old men and require special care. They must be gotten up and out as soon as possible, and they may generally be gotten in a wheel chair on the second day after operation.

Irrigation of the bladder should be used continually or intermittently, according to the amount of hemorrhage, for a day or two and if all goes well, the drainage tubes may be removed on the second or third day. The patient should be encouraged to drink all the water he can take.

The urine drains through the perineal wound a few days but soon comes more and more through the urethra until in from one to three weeks, it usually is all passed naturally. The wound heals very rapidly. The results have been quite satisfactory.

The average time in hospital has been three weeks after operation. There has been no incontinuence of urine, nor stricture, and sexual power is usually preserved. Obstruction to urination has been removed in all cases.

SUMMARY

Drainage is nearly perfect.

Every step of the operation is clearly seen.

Practically all important structures are preserved.

Results are probably as satisfactory as of any prostatic operation.

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THE LANE OPERATION FOR CLEFT PALATE.

MERVIN TUBMAN SUDLER, PH. D., M. D., Lawrence, Kansas.

Read before the Kansas Medical Society, May 4, 1911.

Plastic surgery requires more than ordinary surgical imagination; and the man who can, by his originality, devise new methods that supply deficiencies or aid in overcoming difficulties should certainly be ranked among those who have made two blades of grass grow where only one grew before. No part of this field of endeavor has probably received more attention than the defect that we know as cleft palate.

This pathological condition is caused by the failure of the two palatine processes to unite. With it is usually associated hare lip on one or both sides. We all know only too well the result in the adult if this condition is not treated. The typical pronunciation, often difficult to understand, difficulty in swallowing and other conditions which make the patient shun his fellows or feel the constant embarassment caused by his deformity.

It seems to me that Mr. Lane has enunciated more clearly certain principles in treating this condition than any other authority.

In the first place, the nose, mouth and pharynx develop in their proper relation to one another only when the physiology conforms to the normal type. For instance, nasal obstruction of any kind leads to marked facial deformity, as in adenoids. The nose ceases to develop proportionately, the mouth is held open., the tongue in an abnormal position, so the upper jaw becomes de-

formed, and when the second teeth come they do not fit upon one another and we have a large amount of work for the dentist, and after he has done his best the condition is far from normal. This occurs, to a more or less extent even when adenoids are removed; if they have been present in the pharynx for two or three years. In the same way, enlarged tonsils, or an enlarged tongue, may cause a deformity involving the bony structures as well as the soft parts.

In the case of cleft palate the deformity begins before birth. If the primaxilla is free, it becomes pushed out, the anterior nares become broadened and flattened owing to the absence of the forces which mold these parts into their normal shape. After birth, this process is continued; and if there is no tissue between the premaxilla and the maxilla, this gap becomes larger. The child necessarily breathes through its mouth and the nose and its cavities do not develop in proportion to the other structures. The premaxilla constantly becomes more prominent and develops into a snout which is so hideous in some of these children. So the longer an operation is postponed, the greater the difficulty encountered and the poorer the results, because greater deformity has taken place; and even the most successful operation cannot restore the the function that has been lost from the changed condition. In looking over the review for the various operations of cleft palate in such a work as Jacobson & Rowland's Operative Surgery, the advisability of operating early is insisted upon by Mr. Lane alone. For instance, R. W. Murray of Liverpool says:"As a general rule postpone operating upon the palate until the child is between two and three years of age." Brophy, in this country, recommends operating upon the child before the third month. This is the earliest age, among American Surgeons. On the other hand, Lane says the child should be operated on when one day old; or, as soon after that as possible, so as not to waste any time in controlling the functions of these parts and giving them a chance develop in unison.

These flap operations depend for their success upon the fact that in these children the muco-periosteum covering the alveolar-process and palate can be entirely separated, except at the nasal border, and still maintain their vitality. They in fact, not only maintain their vitality, but if retained in position, will be covered by epithelium in three or four weeks. These flaps are rather complicated; and in order to properly suture them, Lane has devised several instruments: a special needle holder, capable of carrying the small curved needles so they can be placed very accurately; mouth gags with teeth which bite into the gums so they

do not slip, etc. After having used some of the old cleft palate needle holders, I can testify to the great convenience of this special needle holder. I will not attempt to describe in detail just how the flaps are cut for all the various cases. A diagram for almost every condition is given in "Cleft palate and hare lip," by W. Arbuthnot Lane, the second edition of which was published in 1908 by The Medical Publishing Company, Limited, London.

Many of these flaps are most ingenious and there is never any cutting of the bone at any place, at any time. The hare lip is always corrected last; and the pressure of the lip is sufficient to bring the premaxilla back in place in a few weeks.

My experience with the Lane method has been limited to two cases. The first: The soft palate alone was involved in an adult of 28 years of age. In this case the stitches held so that not even a dimple showed in the uvula. The second case: A baby girl 8 months old who had a double fault in the palate, the vomer swinging free in the middle, a double hare lip, and a premaxilla slightly attached on one side only. In this case, it was necessary to take a flap extending from the edge of the cheek, just above Stenson's duct over the aveolar process, and out to the edge of the hard palate.

This was sewn fast, as shown in the diagram, by a double row of stitches. Only the last two stitches, which were in the uvula, failed to hold. A small defect was left between the premaxilla and the upper jaw, Owing to the length of time that it took to get this flap and put it in position, the harelip was left for a later date. In the meantime, this flap became completely covered with epithelium in from four to five weeks. When the child cried, it had lost the peculiar intonation that goes with cleft palate; and it was able to breathe through its nose. About five weeks ago, the lip was operated upon and the nose closed off. Since this time, the gap between the premaxilla and maxilla has closed very rapidly; and at present the gap is smaller than an ordinary lead pencil. The mother reports that once in a while food is forced up into the left nostril through the opening, but this does not occur so often now as it did a week or so ago. In every other way, the child acts like a normal baby of fourteen months. (Lane would have closed the lip at the first operation and used a piece of cheek to have covered this small space.)

It will be seen from this description, that these operations are very different from the Brophy or other cutting or crushing operations, such as have been in use in this country. The shock is certainly very much less. In fact, I am convinced that the

mortality of the Brophy operation is by no means small; and, the results do not seem to me to be obtained by using the same natural forces as in the Lane operation. It is perfectly remarkable how large a flap can be gotten up and one side left absolutely bare of epithelium; and yet in a very short time it grows out and covers this relatively enormous surface. For this flap to retain its vitality, it should go clear to the bone. That is, a thin section obtained in a careless half-hearted manner does not do so well. And the very thin periosteal elevator, originally devised for nasal work, seems to me to be almost ideal for this purpose.

This operation is only beginning to be appreciated in this country; and I desire to emphasize the principles involved. These are so excellent that it seems to me that this operation is superior to any of the others that have so far been devised. In recapitulation, I would say:

1. It is possible to close much wider clefts by means of the flap method than by any other operation.

2. There is much less shock; and the loss of blood is slight.

3. It is never necessary to cut or crush any of the bony structures.

4. It is possible to use it immediately after birth; in fact, the sooner, the better.

5. The palate is corrected first so the "hare lip" gives additional room for performing this operation.

6. Normal forces for shaping and moulding the face and nose are used.

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CONTRACT PRACTICE.

J. N. DAVIS, M. D., Independence, Kansas.

Read at the meeting of the Southeast Kansas Medical Society, at Parsons, Sept. 26,

This so large a subject, so far reaching and destructive, the effects of which seem to have gone unnoticed or considered a necessary evil, many have written upon and discussed it and so ably condemned it, that with my little experience and small amount of investigation, I feel far from able to present this subject to you. But for the fact that much has been said and so little done, do I attempt to add my contribution to the cause. Therefore I ask your indulgence while I briefly present the subject of "Contract Practice". In considering this subject, I shall condemn every form of contract except our fee schedule, because they are all wrong in principle, and with the hope that I may help to stir action against the more pernicious.

In the beginning, I wish to call attention to the parties, who one or all suffer from this practice First, the physician; second, the patient; third, the medical profession; and fourth, society at large. Let us briefly consider how and in what ways these parties may be effected.

I will begin with the railroad contract, as it is undoubtedly the grand-parent of the whole system. Here the physician, —or surgeon, as he is usually called—may be even over-paid and is certainly well protected by the company, for he is working for the company and not the unfortunate persons for whom he cares. We cannot recall an instance where the persons injured by railroads were given the benefit of the doubt, because the surgeon is interested first, in the welfare of the company, and secondly, the patient. Thus a patient may not only be dealt with unjustly, but is made a pauper to be thrown upon the commonwealth. Usually all four parties suffer to a greater or less extent under most contracts.

I will be brief as to mill and mine contracts. This class varies greatly, hence almost without fail the physician contracts to do an indefinite amount of work for a fixed salary. Does that sound fair to the physician? Suppose the physician is required to furnish the medicines, as he frequently does in these contracts; or suppose, as is the case, some of his patrons are very inconsiderate of the doctor, personally, and because their bill is paid, they call him for mere trifles and at all hours of the night. Who is the unfortunate one? Again, if the work is more than the physician can properly do, or is far in excess of the pay received, what may we expect Slight his work and as a result become inefficient, while the patient gets poor care and the medical profession is lowered in proportion as the physician lowers himself and his work.

Before going too far or taking too much of your time, I wish to mention the industrial insurances, as the Metropolitan, and the Prudential, and the lodges, as the Fraternal Order of Eagles, Loyal Order of Moose, Orioles, etc. In this class of work we have allowed ourselves to be imposed upon to the extent that we will make a call—or inspection as they call it—give our time and a certain amount of professional skill for the munificent sum of 25 and 50 cents. And too, we are often annoyed by the families who persist in calling us so frequently as lodge physician, and as a result are tempted to lower the quality of our services. I want to quote you a section from the by-laws of the Fraternal Order of Eagles: "Section 1. It shall be the duty of the aerie physician to attend, prescribe for, and perform such surgical work as may be

necessary, on all members of the aerie in good standing and their respective families, also all visiting members and their families without extra charge, except in cases of confinement, and primary venereal or chronic diseases, or disabilities existing at the time the member made application for membership. The Loyal Order of Moose, the Orioles, the Foresters, the Red Men, and the Maccabees have a similar section.

I shall mention a movement which is promoting contract practice, and is affecting a great many persons, and that is: the fostering by corporations of associations among their employees who pay a weekly assessment. This makes a self supporting organization which pays its contract physician, who is always congenial to the company, thus the company is relieved of considerable responsibiity at no cost, and with a physician who is working for the welfare of said company. This is a very satisfactory arrangement for the company, but permits the physician to be imposed upon, also exploited by the corporation, while the employees get second consideration.

I need not tarry longer on these forms of contracts, for you are all more or less familiar with most of them, and many I have not mentioned. But why do they exist? Some one has said that we are individually responsible, that is, we as physicians and ethical men should not accept such contracts. This might be true if we were one to every 2000 population and like conditions then existed. How many times have we heard the remark: If I do not do it, some other doctor will, or the lodge will import a man who will." Does that sound like individual responsibility, or lack of organization? This constitutes the first and foremost reason why we have this class of practice to deal with, which is none other than the lack of adequate organization. And second, I may mention the so-called commercialism—that everlasting trying to get the best of the deal, and whenever that is accomplished, someone concerned is cheated—and we are objecting, because it is usually the doctor. And the third reason is an over-crowded profession, which we hope to see remedied under the present regulations and restrictions. And too, the indifference of societies, that is, their tolerance and mild discussion, with no definite action. I also wish to mention the fact that the oftentimes personal jealousies make contracts low, and even bidding for contracts possible, and yet you would not think that a medical graduate, apparently sane, would drag the colors in such disgrace.

England, Germany, France, Austria and Norway all have some form of compulsory insurance law, providing that all who

have an annual income below a certain figure, (in Germany it is $476.00) must take out such insurance. This insurance provides them with medical and surgical attention in case of injury or sickness of themselves or families, also a pension for old age or incompetency. The situation is not altogether bright from the physicians standpoint, as shown by their opposition to an increase in the wage limit, and in some instances, even strikes, refusing to work for the contracts offered, which, however, have availed little. This condition is well described in a report on the subject, by Mr. Thomas H. Norton, U. S. Consul at Chemitz, Germany. He states that while the compulsory insurance against sickness and accident, as well as insurance for old age has done much to raise the level of comfort for the working man and their families, yet it has had a decided effect upon the medical profession which is attracting considerable attention in Germany. 'Physicians are engaged by the officials of the insurance organizations at fixed terms, which are usually far below the minimum rate fixed by law for medical services, and which are specifically provided for by contract." The old time relation between physician and patients," says Mr. Norton," are rapidly giving away to a purely business connection, in which the personal equation is of constantly diminishing importance". He says there is keen competition among physicians to secure these appointments and that the low fees paid may tend to encourage perfunctory and inadequate services, also a tendency on the part of those holding policies to abuse their privileges, as you can well see. Finally that the enforcement of compulsory insurance has brought about a distinct lowering of the average compensation for professional services.

The fact that the profession there and in similar instances. compulsory or not, in this country are the ones suffering, does not condemn the law. But why should the physician be paid far below the minimum "when it is safe to say that none of the other officials of the organizations are?" The physicians should not be made an exception, except as he has allowed himself to be. It is not necessary that the profession allow themselves to be exploited for the rest of society, and to prevent this it is necessary to present a good organization and a united position in demanding adequate and reasonable fees. Similar conditions exist with us only on a smaller scale. And if the compulsory low wage insurance is feasible, we will sooner or later have the same situation to deal with, and it behooves us to completely organize and present a solid front to the situation as we have it now, which will prepare the profession for any emergency.

Fight it as we must, and condemn it as we have, the contract system is here to stay, and we must meet it, indeed have and as promptly lost control from sheer lack of business acumen, and organization, which only complicates the situation and makes it the more imperative that we be united in our demands for fair treatment and adequate compensation. As a matter of fact our much extolled and greatly beloved profession is a very poorly planned out affair. It has existed in a haphazard way with little system, which is being remedied perhaps as rapidly as is possible under the circumstances. It has been developing so rapidly that no single individual has been able to keep up. It is no wonder that it has not been governed, nor is it likely to be very soon. While it is impossible to regulate contract practice by the profession as a whole, at least at present, the needs are largely local and examples have been set by county and city societies showing the manner in which such control may be gained. For example, the doctors of Meadville, Pa., have signed a resolution agreeing to cease contract practice for lodges and fraternal societies, and the results are reported as being satisfactory.

Dr. Woods Hutchinson suggests that we take advantage of the law of averages, both of mortality and morbidity, arrange a definite scale of fees for yearly attendance per patient and per family, and devote the best of our energies to keeping our patients well, instead of patching them up after they have fallen sick. This may be good in its day, but certainly is not a panacea for our present ills, because we are most surely not prepared for so radical a change.

The British Medical Association some time ago passed certain resolutions with a view to regulating contract work with lodges and societies, which I do not think worthy of mention only to condemn. I do not think that we should compromise but oust every contract of this nature, and all others possible, for what rights have these societies to exploit a physician for a membership that is well able to pay the regular fees? We will have plenty left to compromise after ousting all of these. I am further of the opinion that this is peculiarly a question for the county societies, with the state society lending what support possible, and soon demanding that county and city societies have adequate regulations of such practice before being admitted into the state association. This can be done by perfect organization, the basis of which exists in most counties, and by a united stand upon such questions, which to my mind might be expressed somewhat as follows: First, a refusal to make any manner of contract with

lodges or fraternal societies, leaving examinations to, "Who-so-ever will", only stating that the fees shall be adequate for the services rendered. Insurance companies will insist upon a minimum number of examiners, to avoid a multiplicity of accounts, which is natural enough, and not such a bad compromise, provided all fees be based upon our fee schedule. Second, that all contracts be avoided except in such cases as where for obvious reasons it is the most practical way. Which should be done by fee, or contract based upon the law of averages and passed upon by the county society within whose bounds the contract is to be fulfilled. Realizing as I do that conditions vary so greatly, it is impossible to offer any set rules. But such variations can easily be disposed of by the individual society to the maximum of satisfaction to all concerned, all depending upon their completeness of organization.

By way of conclusion, I wish to add that I am in favor of compulsory low-wage insurance, and believe that it will come sooner or later in some form and that it is our duty to keep awake that we be not the loser but be benefitted by the arrangement. All of which means complete organization.

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SIGNIFICANCE OF EARLY DIAGNOSIS OF UTERINE CANCER.

E. F. DAY, M. D., Arkansas City, Kansas.

Read before the Sumner County Medical Society, Nov. 9, 1911.

Perhaps in all chronic diseases there is none in which it is of more importance that an early recognition be made, than that of carcinoma of the uterus or cervix, and none in which there is such gross neglect by the patient herself, and sometimes the doctor to whom she recites her symptoms, and who, after finding she is a trifle shy as to being examined, tells her she perhaps has some inflammation and perscribes some astringent douche that she uses week after week, with no cessation of symptoms, and all the while the malignant mass is gradually infecting surrounding tissues and rendering a cure more difficult and improbable.

Of all organs of the body, the uterus seems to present the most favorable site for the invasion of cancer. Welch found in thirty-one thousand cases of cancer, twenty-nine per cent were of the uterus; seventy-four per cent of them were epithelioma of the cervix. Most of them occurring between the ages of forty and seventy years, and very few in women who have never borne children. As to the variety of the cancer, whether it be an epi-

thelioma or an adeno-carcinoma, it makes little difference as to the ultimate results, but in diagnosis there is some difference, the epithelioma arising from the squamous cells covering the vaginal portion and the adeno-carcinoma from the cylindrical cells lining the interior of the cervix.

In epithelioma the disease begins as a small area of infiltration on the vaginal surface of the cervix and usually at a point of irritation from scars, from laceration or old erosions or ulcers. At this stage the patient herself has had no warning symptoms of danger and therefore rarely presents herself for examination. There is no pain, no discharge, and upon examination only a slight induration can be felt. Leucocytes gradually gather around the affected area, the induration becomes harder and larger, a small abrasion or ulcer appears which bleeds easily, a slight purulent discharge is noticed, and it is usually at this time that the patient presents herself to the physican. She has noticed small blood stains between the menstrual periods and especially after coitus or on over exertion, also there is a noticeable leucorrhoeal discharge. The patient has noticed some tenderness but no pain. This condition may exist for some months without any appreciable change, but as the cancer usually spreads by the continuity of tissues there can usually be seen a gradual enlargement of the infiltrated area. It is at this time that a diagnosis is most important and also most difficult. A very large per cent are permanently relieved by an operation, removing all infected tissue, and it means certain death in one to three years if allowed to remain.

To differentiate from chancrodial ulceration, syphilitic lesions, laceration with erosions, etc., is no easy matter. We cannot curette every woman whom we think may have a cancer nor excise a piece of the cervix in order to make a microscopical examination to prove our diagnosis.

In order to differentiate the simple and chancrodial ulcers from the malignant, Heitzman uses ten per cent solution copper sulphate applied for one or two minutes. If the ulcer is a simple erosion a bluish white coating will form, if malignant will cause bleeding. By repeating this every few days the simple ulcerations will soon heal over, while the malignant cases will bleed more profusely with each application. He states by this simple means it is rarely necessary that a microscopical examination be made to make a positive diagnosis. Endometritis yields readily when the cause is removed, while the cancerous growths slowly become more aggravated with all the treatment. As the disease progresses the symptoms become more marked. the ulcer becomes larger

and the discharge more offensive in odor. The patient has more pain, grows thinner, skin becomes sallow and gradually the patient dies a lingering, miserable death. The point I wish to present is this: 1. That the greater number of these cases arise from old lacerations and hard scars from child birth, with consequent ulceration and irritation that is allowed to go on year after year without treatment, and if properly attended early would prevent many of the cancers of middle life. 2. That when the cases of ulceration and induration do not yield readily to treatment and there is doubt as to differential diagnosis, a specimen should be obtained and given to the pathologist for positive diagnosis, and if found cancerous, an immediate removal of the organ and all surrounding tissues that may be infected with cancerous cells, should be done, as there is no other treatment known today that will arrest the growth and development of the disease.

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SERUM THERAPY.

H. GERALD SHELLY, M. D., Mulvane, Kansas.

In the discussion of serum therapy for the treatment of infectious diseases I will use the terms serums and vaccines or bacterines as synonomous. While there is considerable difference in derivation and methods of using, still the underlying principles are the same.

The serums are of greater benefit in acute cases, with toxic symptoms, because of their absorption being more rapid they are better able to cope with the toxic condition present and the rapidly forming bacteria. In the more chronic cases the vaccines are equally as good as the serums.

There is no doubt in my mind, judging from the history of serums and the little experience I have had that the time is coming and not far hence, when serum therapy will be used exclusively for all infectious and contagious diseases.

In Jenner's time the vaccination as a preventative for smallpox was looked upon with great skepticism by many because of the bad results coming occasionally from the vaccination (which was usually the result of a secondary mixed infection) claiming it was the greater of the two evils.

But when they come to the realization of just what vaccination meant, and what it would do, it soon became a universal custom and mankind received through Jenner one of its greatest blessings.

The greater majority of physicians were skeptical in the be-

ginning, of the use of diphtheritic anti-toxin because of one or two deaths, which were claimed to be due to the use of the serum. But Roux, Martin, Behring, Chaillou and Yersin who were ardent believers in its being a specific, would never be content until they had proven its efficiency.

When the American physician received statistics on several hundred cases in which anti-toxin was used they looked upon it with considerable doubt, then with partial belief, and later, when it was fully demonstrated, with full belief in its efficiency.

Prior to this the mortality in all cases was about 55%, now about 11%.

Today there is not a physician to be found anywhere who would not upon the least provocation, use anti-toxin.

The trials of vaccination and of diphtheritic anti-toxin will illustrate the stage through which the serums and vaccines are now passing. The exact purposes and usages are not fully known by the greater majority and are so pronounced a failure.

I want to say before taking up the subject in detail that I do not claim that serums and vaccines are a "cure all"—but I do say that if used judiciously they are in many cases more applicable than any other therapeutic or surgical measures. In many instances I do think they are a specific but generally speaking should be used in conjunction with other therapeutic agents.

Many physicians have used vaccines and discarded them because they did not understand their cases and because the vaccines they were using were not indicated in these particular cases, i. e., for example; pus tubes the first thought is gonorrhoea and so we use gonococcus vaccine—no results are obtained at least no permanent cure—so it is pronounced a failure.

Another illustration is that of pneumonia, the name would naturally suggest the use of pneumococcus vaccine which in all cases is not indicated, and results would be the same if we should use diphtheritic anti-toxin.

As I stated before, diagnosis is of utmost importance. This cannot be made without the microscope in the greater majority of cases. If we are dealing with a streptococcus infection we must use streptococcus vaccine; staphylococcus infection, staphylococcus vaccine, etc. If the microscope is not available a certain few diseases may be grouped under the several heads according to Mathews, thus:

1. Furuncle, carbuncle, osteo-myelitis, suppurating acne and eczema—staphlococcus vaccine.

2. Erysipelas, puerpuel septicemia, septic endocarditis, lymphangitis and cellulitis—streptoccocus vaccine.

3. Peritonitis, pulmonary tuberculosis, and a number of osseous and skin infections—tubercular vaccine.

The time of using in my opinion should be at the earliest possible moment, the sooner we begin our welfare on the toxemia and the bacteria present, the less amount of toxemia and number of bacteria we will have to combat.

The dosage is as yet under discussion. According to Wright this may be determined by the opsonic index, but when this is not practical it should be governed by the effect upon the patient. In chronic cases small doses should be used, the dosage varying with specific vaccine used ranging from five to two hundred fifty million.

The most effective dosage of vaccine varys for different cases and at different times for the same case. In acute cases the dosage may be repeated as often as every twenty-four hours while in chronic cases usually from four to ten days.

The staphylococcus and streptococcus vaccines are more interesting to me, probably because I have had more experience with them, than with others. I regard however, one if not the the most important of the vaccines, that of tubercular. Koch about ten years ago announced the discovery of a substance in culture of the tubercular bacillus which caused a specific reaction in persons suffering from tuberculosis, and which if administered over a sufficient length of time, possessed a curative action over a tubercular process. In this case as is the history of all, great enthusiasm was aroused until disaster came through improper dosage and a lack of thorough understanding at which time it was abandoned. For a number of years it was used for a diagnosis on the administration of which followed chills, fever and general malaise; this reaction was obtained only upon persons who were suffering from tuberculosis.

I wish to quote from a paper by Dr. Edward Oschner of Chicago, read before the Chicago Medical Society, two years ago: "In considering the effects of vaccine therapy upon tubercular processes and joints—it is manifestly impossible to determine their exact influence because we would not be justified in discarding the other therapeutic adjuncts which have proven themselves efficient in treatment of this condition. However, I believe we will be able to show that vaccine therapy has a very decided and if properly applied, beneficial effect upon tubercular joints and can now be looked upon as a valuable adjunct in the treatment of the joint tuberculosis. If patients with joint tuberculosis came to the surgeon sufficiently early, if they are placed under proper

hygenic conditions, if suitable measures are adopted for the prevention of secondary infection, if the joints are perfectly immobilized for a sufficient length of time and if vaccine therapy is instituted under the control of the opsonic index I believe that the greater majority of cases will secure perfect or nearly perfect functional and anatomic results. For the past two years we have been using vaccine treatment as a routing procedure in all of our cases of tuberculosis and rather early in our experience it seemed to me that tubercular cases thus treated reacted more quickly, and in joint tuberculosis it appeared that when the last cast was removed, ankylosis of the joints was less common and less severe. About this time, I had three very interesting cases of bi-lateral tubercular cervical adenitis; in each case I did a radical operation on one side, then placed the patient on vaccination treatment for from six to eight weeks, then operated on the other side. In each case I noticed the following facts: The glands first operated upon had their ordinary gland capsules, but in addition a very considerable deposit of pericapsular connective tissue, the vasclarity of the parts being about as is usually found in these cases. When operating the second time quite a different condition was found; while the gland capsules was about the same as in the first operation; the periglandular connective tissue had almost entirely disappeared. The glands were very much more freely movable and the surrounding tissues were much more vascular than they had been at the previous operation—so vascular in fact that there was general capillary bleeding, interfering very seriously with the rapid dissection. I have since observed the same conditions twice, in fact in all cases, five in number, in which there has been intervals of vaccine treatment between the first and second operation. Process of healing which we believe we have observed here is entirely different; it is fundamentally a phagocytic process; a process of vascularization, instead of a sclerosis; it is a tearing down of the connective tissue wall giving the phagocytes an opportunity to destroy the tubercular bacilli."

I dont wish to burden you with a host of clinical records in which we have used the vaccine for a number of different infectious conditions, but I want to mention a few in which the vaccines prove to my mind conclusively their efficiency.

Case 1. A case of bronchial pneumonia—a child seven years old who was just recovering from the measles, the attack came on suddenly, the temperature ranging from 104 to 105 the first 24 hours. I had a microscopical examination made of the sputum and found a few pneumococci, but many streptococci. Instead

of using the pneumococcus vaccine, I used the streptococcus vaccine. Within four hours the temperature dropped from 104-$\frac{8}{10}$ to 99-$\frac{5}{10}$, stayed there for about four hours then gradually rose until it reached 104$\frac{8}{10}$ again. Twelve hours from the time I first used it, I administered another dose and again the temperature receded to 99 with a gradual rise. Twenty-four hours from the time I administered the first dose, I gave another with a drop in temperature in 4 hours which never exceeded 99½. The case was that of a typical pneumonia which was aborted in 48 hours.

Case 2. A case of bronchial pneumonia—In which case we used pneumococcus vaccine with no results. The following will illustrate the all importance of a correct diagnosis of sputum. The microscopical examination showed strepto-coccus infection and upon the administration of one dose of streptococcus vaccine the delirium was abated, and the temperature dropped to normal.

Case 3. A case of pyemia following typhoid fever.—An abcess of the lung proven by sputum; an abscess in the region of the kidney, which was opened; the liver being greatly hypertrophied and very tender. In this case thirty million staphylococci was used every twenty-four hours until three were used, then every fourth day until three more were used. The boy made a quick and permanent recovery.

Case 4. A case of gonorrhoeal pus tubes. Patient aged 32. Gave a history of having gonorrhoea six years previous with pain in region of ovaries every since. The last two years growing worse, nervous, occasionally chills, followed with fever. This patient had treated with a number of physicians having received at their hands tampon treatment as well as two curettements, but no results were obtained. She came to us with all the above named symptoms plus gonorrhoeal rheumatism. We first used gonorrhoeal vaccine, but no results except improvement in the rheumatism. We made a microscopical examination of the discharge and found a very few gonococci bacilla, but a mixed infection of strepto and staphylococci. We then used the corresponding vaccines, and the patient began to improve immediately. She has been under our care for the past four months and at her last visit said she was feeling better than she had for the last six years. The discharge has ceased, the tenderness and nervousness almost entirely disappeared.

While our experience with the vaccines has been somewhat limited as compared with many others; we have had no results whatever in the treatment of acne, but with that exception, our results have been very gratifying and far beyond our expectations. And as I have said before it is not a cure all but a great aid and

wonderful therapeutic agent in the treatment of infectious diseases. And when the dosage is determined with more accuracy and the bacilli distinguished with more certainty, vaccine therapy will be the greatest of all therapeutic agents in infectious diseases.

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BLASTOMYCOSIS.

C. W. LONGENECKER, Kingman, Kansas.

Read before the Kansas Medical Society, May 3, 1911.

My reason for writing this paper is not that I have anything new to present on the subject, but to call attention to the clinical features of a disease that any of us may be called upon to treat, but is seldom seen outside of large skin clinics.

Blastomycosis was first described as a separate entity by Gilchrist in 1894. Before that time it was considered a form of lupus. It is an infectious disease caused by blastomycetes, a form of yeast fungus. The disease is generally local, affecting only the skin, but a number of cases of systematic blastomycosis have been reported.

The localized form usually occurs at the site of an injury; or there may be only a slight abrasion of the skin, the patient having no knowledge of an injury. It begins as an indolent papule or pustule which soon assumes a warty or honeycombed appearance. The lesion gradually enlarges, and around the margin and sometimes scattered over it, are small holes about the size of a pin or a little larger with clean cut edges and hollowed out beneath the epidermis. From these holes and crevices in the skin pus exudes on pressure and discharges more or less constantly. The discharge forms a yellow crust which on removal leaves a slightly bleeding surface with the appearance of what is known to the laity as a "seedwart." After a time the center may heal while the margin is still spreading forming a ring. There is usually pain and swelling, but this may be slight or absent. The lesions may appear anywhere on the body, but are most frequent on the hands and face, as they are more exposed to injury. In old chronic cases there may be multiple lesions.

There are no constitutional symptoms in the localized form.

If untreated the disease continues indefiintely. Pusey reports a case of over twenty years duration.

As to diagnosis the conditions it most resembles are tuberculosis verrucosa, epithelioma, and vegetating syphilide. The finding of the organisms makes the diagnosis certain.

The prognosis for localized blastomycosis is good if the proper treatment is carried out.

The best treatment is the X-rays or excision and X-rays combined. Besides this the sores should be cleansed daily with hydrogen peroxide and dusted with aristol, or if this produces too much crusting a moist bichloride dressing may be used. Most authorities also recommend potassium iodide internally.

In systemic blastomycosis the indications are that the organism enters the system through the lungs, and the symptoms simulate pulmonary tuberculosis. The constitutional symptoms may appear before the skin lesions. The sputum may or may not contain the organisms at first, and if none are found a differential diagnosis can not be made until the skin lesions appear. The prognosis is decidedly unfavorable. There have been thirty cases reported up to the present time with four recoveries. Treatment with potassium iodide in large doses is the best so far discovered. The rest of the treatment is symptomatic.

Case Report.—Mr. K., aged 57, farmer; has lived in Oklahoma the past ten years. Has paralysis agitans affecting the left arm and leg. His mother had paralysis agitans and a brother has it. Otherwise he has always been in good health. About the middle of July, 1910,, he skinned a small place on the back of his left wrist, he does not know just how. The wound refused to heal and slowly enlarged. He presented himself to me for treatment December 26, 1910. At that time there was a sore on the back of the left wrist four centimeters long by two and one half centimeters wide, having the appearance already described. There was considerable pain and swelling. After a few examinations I decided it was blastomycosis. A miscrocopic examination of the pus showed blastomycetes. I treated him with antiseptics for three weeks without improvement, except the healing of a small patch in the center about one centimeter in diameter. During this time I dressed it daily, cleansing with hydrogen peroxide and applying moist bichloride dressing 1:1000. Occasionally applied Tincture iodine or pure phenol neutralizing with alcohol. January 17, under general anesthesia, I excised the entire area of affected skin, then simply kept it clean and treated as an ordinary wound, until January 23, it began to look as if the disease was returning. I began X-ray treatment January 23; gave him five exposures, the last one January 29, and used aristol dressing. Under this treatment the wound healed rapidly, and by February 1, was entirely well. I gave potassium iodid 30 gr per day during the last two weeks of the treatment.

In conclusion I wish to give credit to Doctors J. M. McKamey and W. P. Callahan for the microscopic work in this case.

THE JOURNAL
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JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS: J. E. SAWTELL, CHAS. S. HUFFMAN, O. P. DAVIS.

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EDITORIAL

County societies might increase the interest and improve the value of their meetings by one meeting occasionally where the entire evening would be given over to the presentation of clinical cases. Other societies have done so, and it has proven to be a big drawing card.

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The annual dues for membership in the State Society are due, payable at once. If you have not paid your dues to your county secretary then do so at once, so that you will be in good standing, to receive the benefits of the society.

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Chiropractors Indorse Capper and Stubbs.—Wichita, Kas., Dec. 30.—Chiropractors of Kansas, in session there today, voted to indorse Arthur Capper as candidate for governor and Gov. W. R. Stubbs as a senatorial candidate to succeed Senator Curtis. The meeting was in session two days, adjourning this evening to meet next in Topeka. A. C. Fay of Topeka was elected president and Anna M. Fay, secretary and treasurer.—News Item K. C. Star.

Now if Dr. Carson will call for a mass meeting of his followers and give their indorsement to Mr. Capper's candidacy for governor, then we would say that he (Mr. Capper's) medical indorsements were full to the overflowing. Since Mr. Capper's policy

seems to cater to the irregulars, it does not require an emmetropic eye to see what the medical profession of the State can hope to accomplish in medical legislation, should he be elected.

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The National League for American Freedom is apparently spending much time and money to defeat the Owen bill for the establishment of a National Board of Health. All over the country, daily and weekly papers (whose animus seems to be paid for at so much per column) are printing attacks on this bill. An example of this can be shown in the following communication, which is printed verbatim.

Chanute, Kansas, Dec. 23, 1911.

Editor Journal,

There was published in our local papers during the past week an article credited to a Chicago paper, an editorial commending the work of the League for Medical Freedom, and condemning the medical profession as a trust that would, were the Owen bill passed, see the Homoepaths and all others practicing the healing art, that were not members of the regular medical profession, ground between the upper and nether millstones.

I prepared a reply getting my material from an editorial published in the Journal of the American Medical Association, Nov. 4, 1911.

One of the papers—The Tribune—published my article. They had received no pay for publishing the Chicago matter. The other paper was paid full advertising rates for publishing the attack on the Owen Bill, by the local Eddyite organization, and felt that they should not grant me space except on the same terms to which I could not reasonably object.

I enclose both articles.

Very sincerely,

J. C. LARDNER.

PILLS AND POLITICS.

"At its annual conference in Chicago this week the National League for Medical Freedom makes a proper protest against the disgraceful attempt, which is now under way to induce Congress to pass a law for the glory and profit of one school of medicine and against all other forms of medical practice.

"It is well that the League has brought prominently before the American people the impudent and injurious features of the bill that ostensibly is intended merely to protect the public health. Allopathic doctors who undertake to use Congress to put down homeopathic and all other schools of medicine except their own, are going far in the direction of medievalism, against which the Government of the United States itself stands as a monumental protest. It is not to be supposed that advocates of the allopathic school of medicine generally approve of this amazing business, for no right thinking American can believe in a state system of medicinal practice any more than he believes in a state church. Support of this scheme of making

politics serve as the handmaid of a particular school of medicine has been secured up to the present time largely by false pretenses. The American public is under obligations to the League for Medical Freedom because of its exposure of this insiduous effort to prepare the way for an allopathic trust in a country which boasts of its love of liberty. All schools of medicine must be permitted in this country to stand strictly on their merits. To legislate in behalf of any one of them, to the injury of the others, would be intolerable. If boosted up by the law, the practitioner of the favored type would not have to rely thenceforth exclusively on his skill and might proceed to lower his standard of efficiency or take other liberties with his legally established position. Keep pills out of politics that the national health and the national ideas of freedom may not suffer."—Chicago Daily News, November 23, 1911.

AMUSING TO PHYSICIANS.

To the Tribune:

The article headed "Pills and Politics" published in an issue of your paper of recent date is rather amusing to the medical profession. The Owen Bill, to which it had reference, states: The New Department of Health shall recognize no school of medicine.

It is not the purpose of the proposed department to have anything to do with regulating the practice of medicine or in any way to interfere with sects and individuals engaged in the healing art.

The Journal of the American Medical Association, in a recent issue, replying to the charges of a similar nature, says: "That it will favor any change or changes in the bill which will make it clear to the deluded sectarian dupes of the patent-medicine interests that the establishment of a national department of health has nothing to do with the individual practice of medicine, and that the passage of the Owen Bill will not, in any way, effect the relations between physicians and patients. The wily "patent-medicine fakirs and the food adulterators are trying desperately to make the Eddyites and the medical sectarians believe that they are in danger of martydom in the near future. As has been repeatedly stated, the federal Congress has no jurisdiction whatever over the practice of medicine in the states. The followers of cults, fads and sects are needlessly exciting themselves. No one has any desire to interfere with their freedom to believe anything they like. But if a change in verbiage will relieve their overwrought minds and calm their excited fears, it is to be hoped that the change will be made.—J. C. Lardner.

We should all strive to combat any influence which this so-called National League for American Freedom might have in our state, and Dr. Lardners' efforts in his community should be commended as well as an example to be followed.

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The Shawnee County Medical Society adopted the following resolutions, in Topeka, January 8, 1912, commending the action of Governor Stubbs in his appointment of the members of the State Board of Medical Registration and Examination and in the Board's selection of Dr. H. A. Dykes for its secretary.

"In consideration of the action and effective efforts of Dr. H. A Dykes to enforce the laws of the state regulating the practice of medicine:

"We, the members of the Shawnee County Medical Society, as law-abiding citizens in favor of the enforcement of all laws, do hereby express our appreciation of the efforts of Dr. H. A. Dykes an and our confidence in his thorough efficiency.

"We further commend the action of the governor in his appointment and the wisdom of the State Board of Medical Registration and Examinaion in its selection of a secretary.

This appreciation from the Shawnee County Medical Society is well deserved by Dr. Dykes. He has done all in his power to enforce the law, fearlessly and without prejudice. His efficiency can not be questioned. His re-appointment will meet with universal favor.

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EDITORIAL CLIPPINGS.

The recent decision of the Missouri Supreme Court defining what shall be understood under law as the practice of medicine promises to lead to much litigation if followed out as some predict. It is unquestionably the purpose of the court that the State Board shall not be hampered and hindered in its efforts to clear the state of fakirs and unlicensed physicians; we can hardly believe that it had contemplated applying the rule to Christian scientists much as we believe that it should be so applied. Be this as it may, unless some higher power than the Missouri Supreme Court intervenes, our State Board now has authority over those who treat disease for pay in the disease. With lesser individuals this means either an exodus or a change of occupation; with Christian scientists it will mean a fight, and a bitter one. Its a great thing, this making a religion of a system of practice, it makes every one aligned with it ready to fight its battles and convinced that any effort tending to its regulation or control is an invasion of sacred and inalienable rights. We will see what we will see.—Medical Fortnightly.

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Salvarsan—A Warning.—Salvarsan is too good a remedy in in which to lose faith, even in the least. The tendency of a number of excellent men would seem to be to still consider this as a better remedy for syphilis than mercury and kali iodid. The frequent repetition of the dose of salvarsan in those cases that do not respond to one, two or three doses is becoming part of the knowledge of the layman, and he is losing, to a great extent, the faith that was engendered by the extraodinary claims for the drug in the beginning. This is due greatly to his comparison between what he was led to expect and what he believes now he can expect; therefore he is inclined to put much less faith in this remedy than does his physician. It is not an uncommon thing to have the patient, for instance one in whom the lesion is of the mucous membrane, particularly on the tongue, and is persistent, or one in whom

a palmar condition resists all other methods of treatment, object to receiving the injection of salvarsan. These examples are given as they are so eminently amenable to the good effects of salvarsan and are frequently absolutely resistent to other lines of treatment. The physician is thereby handicapped by this frame of mind on the part of the patient. The important point is this: A good, sensible view of salvarsan should be taken by the physician. It should be considered preeminently as a symptomatic treatment and a marvelous one, and not as a cure-all. Let us not dispense with time-honored remedies, which are so necessary and which so frequently act far better after the use of the arsenic.—G. D. C.—California State Journal of Medicine.

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SENATOR OWEN AMENDS HIS BILL.

Objections to Senator Owen's bill for a national department of health (Senate Bill No. 1) have come largely from followers of various sects and cults who feared that their business of treating the sick might be interfered with. Many of the more sincere opponents of this much-needed law are evidently too ignorant to understand that Congress can exercise only those powers which have been delegated to it by the states, that the regulation of the practice of medicine stands on the same basis as the regulation of other occupations and trades, which is not a function of Congress, and that any federal law attempting to regulate the practice of medicine in the states would be void. Repeated explanations have been made that Congress has no auhtority to regulate the practice of medicine or any other profession or calling in any state, and that the object of the Owen bill was the prevention and not the treatment of diseases. Apparently, these explanations have not been convincing—Perhaps some people have never heard of them. To reassure those who are honestly opposing the Owen bill on account of such a misconception, Senator Owen last week introduced the following indorsement to his bill:

"That the Department of Health established by this act shall have no power to regulate the practice of medicine or the practice of healing, or to interfere with the right of a citizen to employ the practitioner of his choice, within any state of the Union, and all appointments within the department shall be made without discrimination against any school of medicine or of healing."

It is to be hoped that this amendment will be retained as a part of the bill, although it is entirely unnecessary from a legal standpoint, since it declares that it is not the purpose of Congress to do what it has no right to do. This fact is undoubtedly recog-

nized by Senator Owen, so that the amendment must be intended to remove any possibility of honest objection to the bill. This amendment will doubtless quiet the fears of honest but misguided opponents of the measure, since, after the incorporation of this statement, the only persons who can oppose the measure will be those who have a selfish and mercenary objection to its passage.—Journal A. M. A.

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The Increase of Insanity.—In the belief of perhaps the majority of medical men of the present day insanity is steadily increasing. Some hold the view that mental affections are increasing at an exceedingly rapid rate, and that the world is becoming mad; others contend that the situation has been grossly exaggerated and that as a matter of fact the increase is more apparent than real, due to some extent to the more accurate tabulation of the insane which now takes place. The truth, as usual, probably lies between the two extremes. Insanity has increased, but not so largely as the pessimists assert. In any event, it is instrcutive to consider the opinions of those who have had experience of the question. J. T. Searcy, superintendent of the Alabama Insane Hospital, read before the Medical Association of the State of Alabama at Montgomery in April, 1911, a paper on the subject (Dietetic and Hygienic Gazette, September, 1911), in which he showed from statistics that the increase of admissions into the insane hospitals of Alabama during the past ten years was over 45 per cent., while the population of the State increased only 16 per cent. Similar figures from all of the States of the Union point to a like increase, and other civilized countries exhibit a somewhat analogous state of affairs. Searcy thinks that there is no alternative to an admission that there is a large gradual increase of persons so mentally deficient and defective that they come within the jurisdiction of State care. Moreover, the writer draws attention to the fact that not only has insanity increased, but the psychoses are more prevalent.

Of course, heredity counts for much in that increase. As a nation becomes more civilized, so it becomes the object to preserve all human life. In the old days, the principle of the survival of the fittest held sway, and the weakly ones were for the most part eliminated. In these days civilization is more tender by far, and lives are now saved to propagate their kind which in former times would have perished in consonance, with the stern laws of nature. When all is said, that can be said, concerning this phase of the matter, however, it must be allowed that heredity does not account for all.

In the opinion of Searcy the abuse of drugs is an important factor in the increase of insanity and psychoses. It is difficult always to distinguish between cause and effect. It may be that the drug taker is invariably a neurasthenic in the first instance, but it is most assuredly true that drug taking increases the neurasthenic tendencies and may lead to more serious mental derangement. The offspring of drug habitues, be the drug alcohol, morphine or cocaine, come into the world with an unstable nervous temperment and are unduly susceptible to the effects of narcotics. —Medical Record.

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SOCIETY NOTES.

At the meeting of the Wyandotte County Medical Society, held December 29, Dr. A. L. Skoog presented an interesting and scientific address on acute poliomyelitis; its pathology, with a correlation of the morbid anatomical and diagnostic findings and some recent advances in the pathology and treatment.

The address was illustrated with some fifty lantern slides.

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The American Association for study and prevention of Infant Mortality, met in Chicago, November 16-19.

The following officers were elected for the next year; president, Dr. Cressy L. Wilbur, Washington, D. C; president-elect for 1913, Dr. L. Emmet Holt, New York; vice presidents, Dr. Joseph S. Neff, Philadelphia; and C. A. Otis, Cleveland; secretary, Dr. H. J. Gerstenberger, Cleveland; and treasurer, Austin Mc Lanahan, Baltimore.

The next meeting will be held in Cleveland.

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The Republic County Medical Association at the annual meeting held in Belleville, November 16, elected Dr. John B. Henry, Scandia, president; Dr. Thomas, Belleville, vice-president, and Dr. Jay C. Decker, Belleville, secretary-treasurer.

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Dr. Leon A. Jacobus, Coffeyville, was elected President; Dr. Mansure, Alvane, vice-president; Dr. Clifford R. Spain, Arkansas City, secretary; Dr. Kelly, Winfield, treasurer, and Dr. Ralph W. James, Winfield, censor of Cowley County Medical Society, at its annual meeting held in Arkansas City, November 16.

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At the annual meeting and banquet of the Shawnee County Medical Society held in Topeka, December 5, Samuel A. Johnson was elected president, and Dr. John. N Beasley, vice-president.

Harvey County Medical Society held its annual meeting in Newton, December 4, and re-elected Dr. Richard S. Haurey, president; Dr. Max Miller, vice-president, and Dr. Frank L. Abbey, secretary and treasurer. Dr. Miller was elected censor and Dr. Alfred E. Smolt delegate to the state medical society, all of Newton.

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At the annual meeting of the Wyandotte County Medical Society held Jan. 2, 1912. the following officers were elected:

President, Dr. Geo. M. Gray, vice-president, Dr. W. F. Fairbanks, Secretary, Dr. J. F. Hassig, treasurer, Dr. Thos. Richmond, censor, Dr. C. C. Nesselrode. Delegates to the State Society, Drs. J. F. Hassig and Hugh Wilkinson. Alternates, Drs. R. C. Lowman and C. C. Nesselrode.

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The Northeast Kansas Medical Society will meet at Lawrence, Thursday afternoon and evening, February 8. An attractive program has been arranged.

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The sixth District Medical Society held its annual meeting in Wichita, December 5. Dr. George K. Purves, Wichita, was selected as chairman and Dr. John J. Sippy, Belle Plaine, was reelected secretary.

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The Northwest Kansas Medical Society at its annual meeting held in Colby, elected Dr. Charles W. Winslow, Oakley, president, and Dr. Charles M. Miller, Oakley, vice-president.

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The Golden Belt Medical Society held a meeting at Manhattan, Kansas, January 4. The following program was given:

Surgical Clinic—1:30 p. m. to 3:00 p. m., at Parkview Hospital. Conducted by Dr. J. G. Sheldon, Kansas City, Mo.

Afternoon Session.—Paper—"Iritis", Dr. J. D. Colt, Manhattan.; Paper—"Some Defects of Early Life", Dr. Geo. H. Litsinger, Riley. Paper—"Regeneration of Bones", Dr. M. Truehart, Sterling.

Evening Session.—Paper—"Ischæmic Myositis, with Report of Two Cases, Dr. R. C. Lowman, Kansas City, Kansas; Address—On Recognition and Treatment of Early Manifestations of Insanity, Dr. C. R. Woodson, St. Joseph, Mo.

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The annual meeting of the Western Surgical Association was held in Kansas City, Mo., December 18-19.

The Labette County Society met in Parsons December 27, 1911.

Dr. Julius Rotter reported a case of greatly dilated Stomach with death due to rupture. Autopsy showed very extensive ulcerations, involving the greater part of the stomach.

Dr. George Liggett opened a discussion on consultations which was participated in by all the doctors, many interesting experiences being reported.

The society then proceeded to the election of officers, which resulted as follows:

President, Dr. C. N. Peltz, Altamont; vice-president, Dr. J. A. Vaughn, Mound Valley; Secretary-treasurer, Dr. O. S. Hubbard, Parsons; Censor, 3 years, Dr. P. W. Barbe, Oswego; censor, 2 years, Dr. G. W. Moses, Parsons.

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RESOLUTIONS ADOPTED BY THE LYON COUNTY MEDICAL SOCIETY.

Whereas, It has come to our attention that Mr. Arthur Capper, editor of the Topeka Capital, is a candidate for the nomination for govenor of this great state, and

Whereas, Mr. Capper has regularly and persistently flounted the scandelously fradulent claims of unscrupulous quacks in his papers, and

Whereas, Mr. Capper has frequently solicited to discontinue the practice of publishing such advertisements, but continues their publication at frequent intervals,therefore be it

Resolved, By the Lyon County Medical Society, that we indignantly repudiate the candidacy of Mr. Capper for governor and pledge our best endeavors to bring about his defeat at the primaries and failure there to redouble our efforts at the general election in November, 1912.

J. W. PANNINGTON,
O. J. CORBETT,
W. D. HUNT, Secretary.

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PROGRAM FOR THE NORTHEAST MEDICAL SOCIETY, TO BE HELD IN LAWRENCE, FEBRUARY 8, 1912.

Address of Welcome, Mayor S. D. Bishop, Lawrence.

"Blood Pressure," Dr. Noah Hayes, Seneca.

Paper.—Dr. W. A. Haynes, Sabetha.

Paper.—Dr. W. G. Bouse, Centralia.

"The Cancer Question to Date," Dr. E. E. Hubbard, Kansas, City.

Paper.—Dr. W. F. Bowen, Topeka.

Paper.—Dr. W. W. Yates, Topeka.

Paper.—Dr. H. Milton Connor, Topeka.

"Hematuria," Dr. L. W. Shannon, Hiwatha.

"Anesthesia by Rectal and by Tracheal Insufflation of Ether, with Demonstration of Apparatus," Dr. W. S. Sutton, KansasCity.

"Some of the Newer Problems in Obstetrics," Dr. C. D. Guffey, Kansas City.

"Mental Diseases and Some of Their Relations to the public." Dr. C. C. Goddard, Leavenworth.

"Clinical Experience with Anti-Typhoid Vaccines," Dr. T. Harris Boughton, Lawrence.

Paper.—Dr. E. J. Curran, Lawrence.

"Extra-uterine Pregnancy," Dr. W. M. Mills, Topeka.

"Some Practical Points from Cerebro-Spinal Fluid Studies," Dr. A. L. Skoog, Kansas City.

Paper.—Dr. Geo. M. Gray, Kansas City.

"Some Legal Rights and Obligations of the Physician and Surgeon, Judge J. B. Wilson, Lawrence.

"Tobacco," Dr. E. Smith, Lawrence.

"Hernia," Dr. C. J. McGee, Leavenworth.

"Treatment of Chronic Intestitial Nephritis, Dr. P. B. Matz, Leavenworth.

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Meeting and Dinner.—The Brown County Medical Society held its regular quarterly meeting at the Grand Hotel, on Tuesday evening. Jan. 2, 1912. The meeting marked the annual election of officers, and was preceeded by a coarse dinner. After the dinner a scientific program was given. The principal number was a fine paper by Dr. Shannon of Hiawatha, on "Hematuria," illustrated with X-ray pictures. The following officers were elected: President, Dr. J. O. Ward, Horton; vice president, Dr, J. J. Comer, Willis; secretary and treasurer, Dr. H. J. Harker, Horton. Dr. Harker has had this office for the past two years. The physicians in attendance Tuesday evening were: Dr. Deever, Tairview; Dr. Funk, Powhattan; Dr. Herrick, Everest; Dr. Reynolds, Dr. Ward and Dr. Harker, Horton; Dr. Comer, Williss; Dr. Shannon, Dr. McKnight, Dr. Emery and Dr. Palmer, of Hiawatha.

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The Douglas County Medical Society held a meeting January 9 and elected the following officers:

Dr. L. T. Gillespie, President, Dr. Edawrd Bumgardner, vice-president, Dr. Leon Matassarin, secretary, (re-elected); Dr. E.

Smith, treasurer, (re-elected); Dr. M. T. Sudler, delegate, Dr. Carl Phillips, alternate.

Censors: Dr. James Naismith and Dr. Randolph, all of Lawrence.

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The Western Surgical Association held their twenty-first annual meeting at Kansas City, Mo., December 18-19-1911. The following officers were elected for the ensuing year:

President, Dr. L. L. McArthur, Chicagg; vice-presidents, Dr. W. P. Dorsett, St. Louis; and Dr. B. M. Ricketts, Cicinnati; secretary-treasurer, Dr. Arthur T. Mann, Minneapolis;

The 1912 meeting will be held in Cinnciati.

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NEWS NOTES

Dr. G. E. Knappenberger of Kingman, Kansas, was recently married to Miss Gertrude Johnson of Norton, Kansas.

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The Eclectic Medical College of Kansas City, Mo., has filed suit for $50,000 damages against Drs. Ernest F. Robinson, Frank B. Hiller, M. P. Overholser, Frank Fuson and B. B. Schultz as individuals, though the action is said to be the result of their procedures collectively while acting as the State Board of Health. The claim is made that the board assumed to ruin the school, drive it out of business, and refused to examine their graduates who wished to practice in Missouri.—Medical Herald.

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Dr. Edward Jenner and Dr. William Thomas Green Morton are included by Andrew Carnegie in his list of twenty-one men whom he regards as having done most to improve the condition of mankind; the former as the discoverer of the smallpox vaccine, and the latter as the discoverer of the anesthetic properties of ether.

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OBITUARY,

Stephen Brown (license, Kansas, 1901); of Great Bend; for thirty years a practitioner of the State; died on a Santa Fe train near Newton, Kan., December 8, from heart disease, aged 70.

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James H. Manahan, M. D., Kansas City, (Mo.), Medical College, 1898; of Enterprise, Kan; formerly police surgeon and city physician of Kansas City; died in Topeka, November 29, aged 42.

P. D. Hughes, A. M. M. D.,, a graduate of the Fort Wayne College of Medicine, (Fort Wayne, Ind.,) 1884; of the NewYork Poly-Clinic, 1887; a member of the American Medical Association; the Kansas State Medical Society, the Northeast Kansas Medical Society and the Wyandotte County Medical Society; Professor of Clinical Surgery Kansas State University and Chief Surgeon to Bethany Hospital, died at his home in Kansas City, Dec. 11, 1911.

He was born February 13, 1855, in New Port England.,

He practiced Medicine and Surgery in Brooklyn ,New York for a short time and in Kansas City, Kansas and Wyandotte County for over twenty-six years.

He was inspector in the Department of Animal Industry, U. S. Agricultural Department 1890-2; and was one of the founders of Bethany Hospital to which he devoted a great deal of his time and energy. At the time of his death he was the President and Chief of its Staff, and the head of the Department of Diseases of Women and Abdominal Surgery.

He was recognized as a surgeon of more than ordinary skill and ability and by his death the medical profession suffers a great loss.—R. A. R.

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Sarah E. Wisner, M. D., Hahnemann Medical College, Chicago, 1876; died at her home in Sharon, Kan., October 7, aged 64.

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Reviews.

Vaccine in Puerperal Sepsis.—Broadhead, in the American Journal of Obstetrics, says vaccine therapy has during the last few years been used with varying success, but at the present time the whole subject of treatment of sepsis by vaccines and serums may be considered as still in the very early experimental stage.

The conclusions of the Committee on Vaccine Therapy of the American Gynæcology Society, consisting of Williams, Cragin and Newell, were in part as follows:

Vaccine therapy is undoubtedly a valuable remedial agent in local infections due to the tubercle bacillus or staphylococcus, less so in local infections due to other pathogenic bacteria, while there is considerable doubt as to its efficiency in acute general infections.

In infections of the urinary tract, especially those due to the colon bacillus, it sometimes results in symptomatic cure, but rarely relieves the bacteriuria. The scanty reports concerning the

pyelitis and the pyelonephritis of pregnancy indicate that vaccine therapy is no more efficient than the usual treatment.

In certain cases of endometritis, it appears to reinforce the curative influence of curettage. The reports concerning its use in pelvic inflammatory disease are too scanty to justify conclusions.—Medical Standard.

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The Treatment of Acne by Vaccines.—A complete review of the entire literature connected with this subject is presented by Morris and Dore (British Journal of Dermatology), and their conclusions based upon the experience of many leading authorities are, therefore, quite valuable.

With regard to the comparative advantages of autogenous and stock vaccines, they are disposed to agree with those who hold that the former are the most efficacious, though in some cases it is better, perhaps, to use a stock vaccine from a trustworthy source, owing to the difficulty of cultivating the acne bacillus. If the cultivation of the bacillus be attempted, it is well to inoculate not only the special media on which the bacillus will ordinarily grow, viz., acid agar, glucose agar (anærobically), and oleic acid agar, but also human blood agar, and Loffler's blood-serum. Some forms of this bacillus are peculiarly delicate, and resent change of nutriment, but in general the micro-organism will grow upon the three special media mentioned. It is well to remember that pus containing the bacillus should not be allowed to become dry, as this frequently kills the bacillus.

Some of the observers whose work was mentioned appear to attach importance to the opsonic index in vaccine-therapy. That view they do not share, their opinion being that in this connection the opsonic index may be disregarded.

In conclusion, experience prevents them from claiming more for vaccine-therapy in acne than that it is a useful adjuvant of the ordinary forms of treatment. Occasionally, indeed, the condition will clear up in a remarkable manner under the administration of vaccine, but there is a marked tendency to relapse, and it is usually necessary to continue the vaccine for long periods and to reinforce it with the other measures mentioned. As an auxiliary to such measures it has a place in the treatment of acne, but there is no evidence that it is capable of inducing true immunity. When the real nature of immunization is better understood it may indeed, be found that certain of the local measures that have been referred to, and especially radio-therapy and radium-therapy, bear in the process a part at least as important as treatment by vaccines.—American Journal Dermatology.

The Choice of the Anesthetic.—The various methods of producing general anesthesia and their advantages and disadvantages are reviewed by A. D. Bevan, Chicago (Journal A. M. A., December 2), who, while admitting that nitrous oxid is the safest for short anesthesia, discourages the idea of making nitrous oxid and oxygen the standard anesthetic in a surgical clinic. It is not free from disadvantages in itself and the apparatuses now being introduced by manufacturers are expensive and undesirable. Local anesthesia has a considerable field of usefulness, but he credits very little to spinal anesthesia, which is dangerous and should be used only to a very limited extent. Use of drugs before anesthesia is also advised against in general. His concluclusions are given as follows: "1. The anesthesia must be placed in trained professional hands. 2. The methods of giving the anesthetic and the apparatus employed should be as simple and uncomplicated as possible. 3. The anesthetic mixture and sequences, like the old shotgun prescriptions of the past, should be avoided and the patient's life not jeopardized by the administration of two or more powerful poisonous agents at the same time, one of which might intensify the action of the other or mask the ordinary danger signals. 4. For routine work, ether, by the open or drop method is the safest and most satisfactory anesthetic and, in the usual run of cases in a hospital service, the anesthetic of choice, in from 75 to 80 per cent of the cases. 5. Chloroform must be discarded as a routine anesthetic. It produces too many immediate and late deaths to warrant its general employment. It is only in the exceptional case, as possibly in a laryngectomy in which one might feel that the direct introduction of chloroform vapor into the trachea might produce sufficiently less irritation to the tracheal mucosa with less risk of pneumonia, than ether, that we should be warranted in employing it. 6. Nitrous oxid is the anesthetic of choice for short operations, manipulation and examination. It is also the anesthetic of choice in operations on patients with seriously impaired kidneys and often on patients in extremely bad condition, as typhoidal perforations, general peritonitis, etc. It should not be employed in patients with bad hearts. It is not so satisfactory an anesthetic as ether and should not be employed in preference to ether in patients who are good surgical risks. 7. Local anesthesia with cocain and similar agents has a limited field of usefulness. The amount of cocain employed by infiltration should always be short of a toxic dose, from $\frac{1}{10}$ to $\frac{1}{4}$ of a grain. It should be employed in normal salt soution with small amounts of epinephrin. Where the amount

does not exceed $\frac{1}{10}$ of a grain it may safely be preceded by a small dose of morphin and scopolamin (hyoscin). 8. Spinal cord anesthesia has to-day no place in surgery. 9. The use of morphin and scopolamin before a general anesthetic brings with it dangers which are not compensated for by any advantages, and the method should be abandoned or limited to specially selected cases. Finally, I believe that the time has come when we must here in America, make a place for the trained professional anesthetist on our surgical team." Bevan thinks that women make the best anesthetists, just as they make the most reliable and conscientious operating-room nurses.

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Splenic Anemia.—A case of slenic anemia differing from the ordinary run of cases is reported by H. L. Hull, Philadelphia (Journal A. M. A., December 9). This fact, with the comparative rarity of the disease renders it of interest. The special features to which he calls attention are the absence of hemorrhages from the mucous membrane (epistaxis, hematemesis, etc.,) which are so common in the reported cases, and the presence on several occasions of an excess of eosinophils, of myelocytes and nucleated red cells. The irregular and elevated course of the temperature for over a period of at least three months and continuing until the time of the report is also noted as unusual.

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Obstetrics Among Indian Women.—The generally accepted opinion that obstetrics, among the American Indian women is always a simple matter, is, according to F. Shoemaker, Albuquerque, N. Mex., (Journal A. M. A., January 6), hardly a true conception of the matter. The Indian women are becoming more and more in the habit of calling white medical assistance, and he reports briefly four cases, one of urethro-vaginal fistula after labor with other complications, one of calcareous degeneration of placenta, one of severe localized infection with high temperature, and the other a tedious labor with twins lasting over four days and requiring active measures to bring it to an end. These cases, with others of like charcater which have come under his observation, suffice to show that Indian women are subject, like the whites, to serious accidents in the function of parturition.

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MISCELLANEOUS.

WANTED.—A DOCTOR.

Good location in town of 500 in South-eastern Kansas. Nineteen hundred dollars, ($1900.) will buy drug store, worth

$2200. And $600 will buy nice 5 room house, can step into a $2500 a year practice and make $1200 a year out of drug store, by taking above.

Dr. Fred Calhoun, Fredonia, Kansas.

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Men of decision all meet with derision; Cromwell's is still a name of opprobrium. Disraeli was depised by millions. Lincoln was reviled by his antagonists. Weaklings neither wear or weave the crown of thorns. Can't you see how absolutely impossible it is to be clear visioned and upright and un-compromising and true to the highest dictates of duty, citizenship and conscience, without arousing a hubbub from every man who detects his fall in your rise?—Richmond Journal of Practice.

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If thou art worn and hard beset
With sorrows that thou wouldst forget;
If thou wouldst read a lesson, that would keep
Thy heart from tainting and thy soul from sleep,
Go to the woods and hills! No tears
Dim the sweet look that Nature wears.

—Texas Medical Journal.

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The Greatest Living Philanthropist is a Doctor.—Dr. D. K. Pearsons, who resides at Hinsdale, near Chicago, he having practically completed the distribution of his entire fortune amounting to about $7,000,000. Needless to say, Dr. Pearsons did not accumulate this fortune in the practice of medicine, which he abandoned many years ago. He has given his money mainly to small colleges, and now that it is all gone, he has presented even his elegant home to the little surburban town in which he lives, to be used as a library and museums while he is spending the last few years of his life—he is now ninety-one—in a local sanitarium. Medical Fortnightly.

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THE MYSTERIES OF SLEEP.

Sleep is one of those peculiar mysteries the solution of which up to the present time is unknown to both the scientific specialist and the man on the street.

The "London Pictorial" tells us that many curious facts have been recently discovered about it by the world's savants. For instance, when we sleep the lower half of us weighs more than the upper half. The brain is lighter and the legs are heavier. Ex-

periments have shown that if a man goes to sleep on a bed suspended exactly at the middle point of his weight his head begins to tip slowly up and his feet to go down. This is due to the fact that when we sleep the blood in the brain goes off to the other parts of the body. The moment the brain wakes to life again it draws the blood back.

It happens when one is fast asleep some part of his brain or several parts of it may at the same time be awake. A man may walk, talk, sing or solve mathematical problems, and yet at the same time be safely in the land of nod.

It seems hard or impossible to decide what part of the brain does sleep. Our sense of time, for instance, is stronger when we sleep than when we are awake. Experiments conducted some years ago on a number of men and women between the ages of 20 and 30 showed that 60 per cent of them were able to wake up in the morning at any time they had decided upon the night before. As the "Pictorial" expresses it, the resolve seems to wind up some thing in the subconscious brain, and when the hour has arrived the clock gives in some mysterious way the alarm and the eye-lids open.

Another curious fact about sleep is that the further the part of the body is away from the brain the less soundly it sleeps. A touch on the toe will awaken one much more readily than a touch on the shoulder.—Canadian Practitioner.

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THE VALUE OF A SMILE.

I know a fellow who got a big loan from a bank just because he smiled when they told him that he couldn't have it. The staid old bankers knew and he knew that if he failed to get the money that the jig was up with him and that the ghost would fail to walk in his place of business the following Saturday afternoon.

But instead of kicking and cussing and damning everything and everybody he just smiled and started away. And the bank people called him back and told him that they had changed their minds.

The smile did it!

And I once knew a young man who was made manager of a big concern because he smiled every time a tough job was given him. And I knew another man who smiled when his fortune was wiped out. That smile made friends for him and he is a rich man today.

There is money in a smile. If you don't feel like it, smile anyhow. If you are lock-jawed and can't smile, make a noise

like one and your companions will appreciate the effort and the effect will be just as good. I knew a little chap who licked a big bruiser because he smiled when the fight began. The smile made the big fellow th nk that the little fellow had a punch that he hadn't suspected. The little one knew that he was in for a licking, but he made up his mind to take it with a smile—and the s.nile did the trick. This first blow made the big fellow quit.

Smile Take your medicine if you have to but take it with a smile. The blows of fate never hurt the man who takes them with a smile. If you are knocked down, get up smiling! If you go broke, smile! I will not make you any poorer. If you are getting the worst of it, smile. You have had the worst of it, anyhow, so smile!

If you lose your job, smile! It may get you another one and anyhow nobody is going to hire a grouch if he can help it. A grouch works three times as hard as a cheerful man doing the same thing. A grouch can be knocked out with one punch, but you have to harpoon and parboil the man who smiles be ore he is licked.

A smile helps you and it helps the other fellow. A smile on the face of a man in hard luck :n the battle of life is worth all the frowns that an army of grouches can scatter. The gloom-look costs money and friends—the smile makes them. Smile!—Beach's Magazine.

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AMONG THE DOCTORS.

When I fell sick in China, they called the doctor in; he pounded on a tom-tom, and raised a rightful din. He said: "The evil spi its must first be chased away, and then I'll change the treatment, and make a tea of hay; I'll give you shredded toads ools, and ink and powdered nakes and burn some yellow feathers, and thus cure up your aches. This house can know no healing till ghosts a e chased th r from so watch me play the cow-bell and beat the Thomas-tom." When I fell sick in Kansas, the stern physician came, and spent the morning working the diagnosi, game; he pinched me in the arynx, he poked me in the lung, he hi me with a hammer, he squinted at my tongue. And then he groaned with pity, a d scratched his whiskered jaw, and said: "It's bunionitis—worst case I ever saw! Just bring an ax and bucksaw, and water in a keg, and sit upon his forehead—I must hew off his leg." When next disease has got me, and I am sore afraid, I'll hustle back to China, where doctors know their trade. —Walt Mason.

CLINICAL NOTES

In carcinoma of the bowel local signs appear first and deterioration in health later; in intestinal sarcoma, impairment of health is first noted and local signs appear later. In carcinoma obstructive symptoms are the rule, in sarcoma the exception. In carcinoma the growth of the tumor in relatively slow, in sarcoma it is rapid.—American Journal Surgery.

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The examination of the prostate gland per rectum, is best accomplished with the bladder empty. After natural micturition, draw off the residual urine. In this way, more correct knowledge of the size and other features of the gland are obtained than if the bladder be distended.—American Journal Dermatology.

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In late carcinoma of the cervix with extensive destruction of tissue much benefit will usually result from a very thorough use of the actual cautery, At times this procedure will result in an arrest of the disease for several years. It will always temporarily remove an offensive mass and reduce hemorrhage. Later, to prevent bleeding and arrest an offensive discharge, the application, by means of tampons, of a powder composed of equal parts, by bulk, of boric acid and tannic acid, will be found of service. If the discharge is very offensive, a powder composed of equal parts, by bulk, of iodoform and tannic acid, applied freely on dry non-absorbent cotton tampons, will afford great relief. Ralph Waldo—International Journal Surgery.

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Correction.—In the December issue a prescription of Dr. Savage, (Tennessee State Medical Journal, March 1911), for inflammation of the middle ear in children, was given and through printers error the wrong proportions were given. It is to be given internally and should read:

Inflammation of the Middle Ear.—Savage (Journal Tennessee State Medical Association, March, 1911) recommends the following for internal administration when the patient is a child and the cause is either grippe or a cold

℞ Tincture of aconite, ... ♏xxx;
Tincture of opium, deodorized, ... ♏xxv;
Sweet spirits of nitre, ... ℥iv;
Syrup balsam of tolu, to make ..... ℥ij.
M. Teaspoonful every three hours, while fever continues.

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When vomiting and right iliac pain or tenderness are associated with a chill and a pyrexia of 105 degrees or 106 degrees, ex-

clude pneumonia and malaria before operating for appendicitis. If the appendix is diseased, exclude mesenteric thrombosis before closing the wound.—American Journal Surgery.

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Any menstrual irregularity or abnormality in a woman who has hitherto been perfectly regular and normal in her menstrual periods, should always suggest the possibility of an ectopic pregnancy.—American Journal surgery.

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A peritonsillar abscess as a rule i more pain ul than serious. But one should not forget that patients have died of suffocation and that er sion of a vessel may take place in the wall of the cavity and cause death.—American Journal Surgery.

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To syphilis may be attributed many cardiac lesions. Acute myocarditis freq uently is due to this disease. Gummatous depos ts in the heart substance will occasion much distress. These facts point to the need of inquiring closely into a heart subject's history.—American Journal De matology.

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Book Reviews.

Practical Medicine Series. Vol. III, 1911. The Eye, Ear, Nose and Throat. Edited by Casey A. Wood, C. M., M. D., D. C. L; Albert H. Andrews, M. D., and Gustavus P. Head, M. D., Chicago, Ill; Published by the Year Book Publishers, 40 Dearborn Street. (Price $1.50) .

This book edited by such well known writers is up-to-date and a good *resume*, of all that is new the past year in its department.

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International Clinics. A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, and Other Topics of Interest to Students and Practitioners. By Leading Members of the Medical Profession Throughout the World. Edited by Henry W. Cattell, A. M. M. D., Philadelphia, U. S. A. Volume III. Twenty-first Series. Philadelphia and London: J. B. Lippincott and Company. 1911.

This volume is abreast of the times and presents a new feature in a section on the economics of medicine, consisting of an article on successful Practice and another on Economic Conditions Affecting Medical Practitioners. It is one of the best volumes of the series.

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PHYSIOLOGICAL CHEMISTRY OF PSYCHIC EMOTIONS.

DR. J. M. WINEGAR, Hamilton, Kansas.

Read before the Kansas Medical Society, May 3, 1911.

If it were possible to place an emotion under the microscope and get a view of its component parts or into a test tube or crucible and separately analyse its elements by a chemistry reaction, this would have been long since done. If not by American chemists then certainly by the German.

We must take the body as a whole in studying the reactions of emotions. The entire combination of systems which constitute the body and makes of it an apparatus through which the most delicate and intricate chemical reactions occur and which are tied together, as it were, by an inter-communicating wiring of nerves and blood vessels and presided over by the central station—the mind.

This gives the general outline of the laboratory within whose walls the various psychic phenomena are to be observed and studied.

We know but little excepting by comparison, and in comparing some of the secretory and excretory glands such as the mammary, for instance, and take into consideration the well known physiological facts in relation to its being so intimately under the control of the nervous system, that emotions of anger, fear, fright and grief will not only retard and stop for the time being the secretion of milk, but we are led to believe the constituents as well are changed, at least, from its effect on a child.

The effects of the emotions on the kidneys, heart, bowels, salivary- and lachrymal glands are too well known to need more than to be mentioned but when we come to consider those other glands whose

functions are so intimately related to the chemical vital functions of the body (I refer to the liver, spleen, pancreas, suprarenal and thyroid glands) and realize if they are as readily subject to the emotions as are those already mentioned, it is enough to cause us to sit up and take notice. From any angle of reasoning, I cannot comprehend why the latter should not be more readily influenced by psychic emotions than the former. For, if as physiology teaches, (that all mental activities are accompanied by neutral activities) and there is so close a relation existing between them that whenever the mental is deranged the accompanying neural is deranged, and vice versa, we begin to understand how the emotions play so important a part in the physiological functions.

Quoting from a recent work on physiology (Sajous) it is the function of the sympathetic system and sympathetic center to govern the caliber of all arterioles and to regulate through the spiral muscular coat of these vessels, the volume of blood admitted into the capillaries of any organ, including those of the brain and nervous system. And that the posterior pituitary body is the seat of the highly specialized centers which govern all vegetative or somatic functions of the body, and of each organ individually. That owing to this fact the posterior pituitary body is the sensorium commune upon which all emotions, shocks, psychical or traumatic, concussions, etc., react. The resulting impairment of its function being the cause of the morbid phenomena observed under such conditions.

If this is physiologically true it is psychologically true and gives us a clue to the various derangements caused by dominating thoughts and obsessions, down even to those vital chemical changes where chemical action ceases and nerve force and thought begins.

If thought, mind and reason are the result and object and final end of the various physiological chemical changes wrought out in the organism, then thought, mind and reason ought to be powerful and potent therapeutic agents in influencing the processes by which they are brought into being.

The field of objective medicine is rapidly narrowing and the field of subjective medicine is one inviting exploration, and psychologic therapy will find reason for its being in physiological chemical action.

The psychic element in the cure or treatment of the ills of humanity is as old as the race. When man evolved first from his garments of hair and began to leave to posterity records of his own and former times, we find woven into such history cures of an astonishingly marvelous nature, which to the present day psychologist means only a correction or changed dominant thought.

Without mentioning, however, all of which are common to anyone who will take the time to read and look them up, I will merely mention the fact that to whomsoever does they will find them surrounded by some sort of religious worship, which at the time and place, held the minds of the people in its grasp.

This has been true all along the paths of human endeavor, even up to the present day. Doctors of medicine today are all too well aware of this condition, but in their materialism, or in their materialistic research, it seems that only a very few have reached an eminence where, without predjudice, or bias they can view the situation and proclaim their views.

It has been said with some degree of truth, I fear, that doctors of medicine of all the professions are most devoid of sentiment, and consequently materialists. This may come from many causes, chief among which is that there can be no effect without a cause, and in the physicians cases, diseases are the effect, which are vividly material so the cause should be material, as well as the effect. Of course there are isolated instances where this does not hold in the everyday routine of us all. I mean the common neuroses of the class called hysterical or neurasthenics. And this common and increasing class should put us to thinking.

There are sign boards all along the way to direct our attention to the psychic; to the mind as well as to the body.

Now an error of the mind has the same effect as a truth, so far as its psychic effect is concerned on the body of the individual. And is only a little different in kind from the mind of the savage, whose mind, in its primitive state, looks upon disease as an unseen enemy, feeding on his vitals and that has to be disengaged and banished by some incantation that may scare it away.

Now, all this leads up to the general public's conception of the healing art at the present time. The medical man does not have to be much of a reader or student to realize that greater and more far reaching discoveries for the alleviation of human bodily ills have been made in the last three decades than in all the time prior to that date. But how is it with the public who do not know of these discoveries and who are slow to believe when told. And the profession in general are too busy or to modest to start a propaganda of education of the masses as to their part in the matter. The tuberculosis crusade has done a great deal along the one line although it has fallen far short of pushing it to the logical end.

The field of the mind has been left open for the charlatan religious miracle worker and all sorts of fakirs, who find in it an easy road to money making and at the same time giving them a noteriety which they find to gratify their own egotism.

To mention them would be to repeat what you all know, for they flaunt their paid advertisments in the columns of the daily press as news items and appeal through these sources to the public to free themselves from their family physician as from a pestilence and fly to them for health. And thousands are doing as they are told to do, and returning home declaring themselves cured and well and in turn become walking advertisments to the truth of the absurd claims of these montebanks to whom anatomy and physiology are only names

To the psychologist it is all as plain as any law or principle underlying any science. And in this it is the law of suggestion.

If the suggestion is made strong enough and emphatic enough, no matter how absurd its fundamental claims, the result will be the same as though based on the most logical hypothesis, and for us as physicians, to ignore or scoff or to maintain a dignified silence is to ignore or scoff at any basic principle on which a great science rests. The field is over ripe and is being exploited by those not in the medical profession, and is being worked to the detriment or shame of the profession of medicine by a set of self styled scientists and professors that do not know even remotely the tool they use or by what means they accomplish results.

Many, no doubt believe that they have by chance stumbled onto a real cure all, as in the case of Wichita's wonder, with his eye water, composed according to a recent analysis of equal parts of sugar and salt dissolved in large quantities of hydrant water.

It seems to me that there is an opportunity for a specialty such as has not been open to any of the other crowded specialties in America, and why the study of psychology has not been taught in our medical colleges, and a working formula been devised so that a student taking a course could not go out and treat cases with as great assurance and expectation of success as any other of the not exact specialties, I do not know.

Some of the American schools of medicine are beginning to wake up to this call, but so far as I know, it is only in a half hearted way. And their precepts are not available outside the insane asylums, where, I understand, they are extensively used almost to the exclusion of all other means—suggestion.

Logically, if suggestion has proven so effective in such cases that have had to be placed under restraint in an institution of this kind, how much more effective should it be in the hands of a specialist among that large and ever increasing number that perhaps never will reach the stage called insane, but who are in need of assistance in untangling their chaotic thoughts fully as much as

those farther advanced. With all the advances and discoveries in physiological chemistry and preventive medicine, and the action of the ductless glands and internal secretions and their influence on the body to preserve its normal equilibrium as given by Sajous in his excellent work down to Ehrlichs salvarsan, all of which are revolutionary in the great field of medicine and are upsetting former theories, yet the psychic chemistry, the major part at least, as yet, remains an unexplored territory. I mean that chemistry which is set to work continually by the numerous emotions that are forever shifting and changing in proportion to the varying suggestions that stimulate ,retard, and agitate the mind, and to which all mankind are subject, not excepting doctors of medicine.

That the mind has a great influence on the body has long been a recognized fact, and to no class is this fact better known than to the medical fraternity.

And why this important and fertile field has been allowed to grow up with all kinds of noxious growths, I cannot answer.

The successes of the most flagrant chalatanry (for in many cases we must acknowledge success), should put the regular profession of medicine to work, to study, to teach, to devise ways and means to use the psychic in this class of miserables, and to do it without loss of dignity or ethics to the profession of medicine or pandering to the mysteriously occult" Black Art", or "Evil Eye."

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CANCER, THE LACK OF EARLY DIAGNOSIS AND THE DISASTERS CAUSED BY IMPROPER TREATMENT.

DR. R. M. BENNETT, Mound Valley, Kansas.

Read before the Kansas Medical Society, May 3, 1911.

In using the generic term "cancer" we include, epithelioma, carcinoma, sarcoma and any other pathological condition that has a tendency to develop into malignancy. And in view of the fact that it is becoming more prevalent all the time and there is no race or class of people exempt from it. We believe the salvation of the people depends largely on the regular practitioner and with him it depends on the early diagnosis, and if we accomplish anything along this line we will have to get out of the habit of telling our patients when they become alarmed about their condition, to let it alone and do not bother it until it bothers you." This is the advice frequently given a patient by the family physician, which too frequently proves disastrous to the patient and is a poor way

for the physician to hide his ignorance. Cancer in the beginning is a local disease and as a rule can be cured. Our greatest trouble is failing to recognize the seriousness of these conditions early enough. Any wart or mole or chronic chapped lips that commences to cause alarming symptoms to the patient should be looked upon with grave suspicion by the physician and never considered as a trivial affair. It is the little things in the practice of medicine that mades us proficient diagnosticians and successful in our work, if we only give them the proper consideration. Many are the patients who have gone to their physician and told him of a peculiar symptom that a wart or mole was giving and allowed to go out without any warning as to what the outcome would be, and a year later come in and tell the physician that they believed they have "cancer", the patient having made the diagnosis himself.

We find that every race of people on the globe, regardless of station, habit or custom, is subject to cancer and some authorities claim that it is more prevalent during middle life, but it has been my observation that the far greater majority of them develop cancer from 50 to 70 years of age and most of them are able to give a history of some previous injury in the location of the cancer.

This suggests to us that there are at least two contributing factors to the development of cancer. We will start with the hypothesis that there are many embyronic cells lying dormant in the tissue. Now suppose these embyronic cells are jarred loose from their abode and raised from their slumbers by some traumatic injury to the surrounding tissue. This traumatism may cause scar tissue or it may simply cause a disturbance of the circulation or cause a stagnation of blood in this region. Any how the circulation is not free as as it was once, then our slumbering cell may raise itself from its long slumber and commence its rapid but insidious development or it may still remain dormant till age or some disease commences that lowers the vitality of the patient below normal. Then our little slumbering cell awakens and takes on activity. Now there is where the first mistake is usually made. The first system the patient will notice is an unnatural feeling. It may be the sensation of a bug or worm crawling on the surface or it may have been a sharp picking sensation. The patient soon finds himself continually examining the location of the newly found sensation. Next he finds a roughening of the skin or the beginning of a small tumor. Now at this stage a microscopical examination might not show anything definite, yet this is the time when the malady should be treated with suspicion and its development apprehended if possible.

These patients after so long a time commence to be alarmed at the continual reminder that there is something there. They consult their family physician and he often makes the fatal mistake of telling them, "not to bother it until it bothers you." The facts are, it is already bothering the patient or he would not have applied for help. At this time and at the beginning the cancer is a local disease and as a rule can be cured. If allowed to go on for months or even years it commences to contaminate the surrounding tissue and continues to throw out its actinic rays until the lymphatic system is involved. Now with the knowledge of the fact that cancer is becoming more prevalent all the time, it stands the regular practitioner in hand to be able to recognize them early in their onset. Any wart or mole on any part of the body that is continually irritated and after middle life commences to grow and have peculiar darting pains or creeping sensation, as an insect crawling, should be regarded at once as a probable cancer and treated as such. Any woman who notices a lump growing in the breast should be told at once that in all probability she is a developing cancer, and if treated at once will stand a fair chance for recovery; but if allowed to remain unmolested will sooner or later sap her vitality forever. The laiety should be taught the necessity of quick action in this direction and they should receive that training from the medical profession. We believe that a great many more of these patients could be cured if they were apprised of the danger in due time and then act on that knowledge.

The excision of a syphilitic chancre while it is the initial leison has been known to stop the development of any other specific symptoms and prevent it from becoming a systemic disease.

We believe that the early excision or amputation of a beginning cancer that may start from an irritated wart or mole or that has started a new developement from any other cause would have the same effect. It is a great deal easier to prevent a thing than it is to stop it after it has commenced a rapid developement. Some of the pastes will do the work nicely if they are applied before the disease has reached the lymphatic system. but to use the paste after the lymphatic system has been invaded is not only a loss of time but takes away a great deal of the vitality of the patient. We further know that the early excision of a tumor of the breast will arrest the development of the tumor and in many cases prevent it from ever causing the patient any further trouble. We believe that a great many of these cancer patients might be saved if we did not spend so much time in trying to make an absolute diagnosis and trying unsuitable remedies.

Now there is as yet no specific for cancer yet we do believe that the early excision or amputation is the proper treatment for those located where this treatment can be rendered.

Now the disasters caused by improper treatment are many. I have seen cases of well developed cancer that had been treated by topical applications of carbolic acid, others of zinc, lead and arsenic, without any regard as to the results they expect to get by the application, in fact we find that almost every drug in the Materia Medica has been used for these ailments and in most cases the physician who is treating the case does not even know what he expects to do. Vaseline, X-ray, radium and everything under the sun is used.

We believe that the x-ray, the violet-rays and radium rays have been known to stop some cases of epithelioma but we further believe that its general use is one of the greatest mistakes that can be made in the treatment of cancer. If the malady has reached through the skin proper or invaded the lymphatic system we believe that every application of the x-ray or radium simply makes the malady worse by weakening the surrounding tissue and causing a more rapid developement of the malignancy.

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THE PERINEUM, FUNCTION, IMPAIRMENT OF FUNCTION DUE TO LACERATION-REPAIR.

DR. H. H. HEYLMUN, Hutchinson, Kansas.

Read before the Kansas Medical Society, May 3, 1911.

I probably ought to apologise for appearing before you with a subject that has been so thoroughly dissected, discussed, lacerated, and repaired as has been the perineum. However, a little brushing up occasionally on an old subject is good for all of us, and the fact also that some of the ideas I am going to advance (for most of which I am indebted to other writers) are not as popular as they might be, furnishes my excuse for being here.

We will begin the physiology of the perineum with the dogmatic statement that the perineum body is not a support for the pelvic organs as formally taught but is simply a buffer, against which the faecal mass collides before being evacuated.

We will attempt to substantiate this statement by describing the act of defecation in the normal individual and the interference with this normal process, and the displacement of the pelvic organs which develop as a result of a partial laceration of the perineal body.

Whether or not, the pelvic fascia fills a major or minor position in the formation of the pelvic floor is not a part of this discussion, however, to bring the points out I wish to make, it will be necessary to consider somewhat the anatomy of the levator ani and the sphincter muscles.

The anterior fibres of the levator ani arise from the posterior service of the pubic bone and are inserted in the central tendenous point of the perineum, passing on either side of the vagina. These anterior fibres are described by Gray as sometimes being separated from the balance of the levator ani by connective tissue.

The sphincter is a thin flat elliptical muscle arising from the apex of the coccyx and having its insertion in the same tendenous point of the perineum. Thus we see the perineal body is a fibrous wedge, suspended between the pubes in front and the coccyx behind; and that the tonic contraction of the sphincter behind just balances that of the levator ani in front. The position of the perineal body being somewhat analogous to that of the central tendon of the occipito frontalis.

Increased abdominal pressure such as accompanies every physical exertion must of necessity be born by the pelvic floor and this in-increased pressure is met by a corresponding increase in the contraction of the levator ani and sphincter muscles. This contraction draws the coccyx forward shortening the antero-posterior diameter of the outlet and drawing the perineal body more snugly against the arch, thus protecting the orifices.

Now in the individual with a normal perineum defecation is begun by the inhibition of a center in the lumbar portion of the spinal cord, through the activity of which the tonic contraction of the sphincter in maintained. The relaxation of the sphincter permits the tonic contractions of the anterior fibres of the levator ani to draw the perineal body forward under the arch, thus protecting the vaginal orifice, enlongating the anus and straightening the rectum, which as you all know, has an acute angle just within the sphincter. Now suppose the levator ani fibres are torn the result is that the central tendon no longer marks the nuetral point as regards the muscular power of the sphincter and the levator ani.

The balance of the power in transferred to the sphincter and its tonic contraction gradually exhausts the remaining fibres of the levator ani, causing the perineal body gradually to be drawn backward. Now, the act of defecation is changed, when the sphincter is relaxed by the inhibition of the spinal center, the fibres of the exhausted levator ani fail to draw the perineal body forward. The entire pubo-coccygeal sling is relaxed, the vaginal

orifice is unprotected, the rectum is not straightened, and the sphincter is not dilated.

On account of this angle in the rectum and the obstruction of the relaxed but undilated sphincter at the rectal opening, constipation supervenes. Peristalsis lags, the rectal mucosa becomes tolerant to large masses of faecal matter.

The constant pressure of the mass against the posterior surface of the perineal body tends to push that body forward between the remaining fibres of the levator ani, the rectum becomes more acutely bent, constipation more marked and the dragging downward on the anterior wall of the rectum more severe.

The anterior wall of the rectum being intimately adherent to the posterior wall of the vagina, can only descend by bringing with it this vaginal wall.

The next step is a dragging forward of the cervix by the vaginal wall until the round ligaments are sufficiently stretched to permit the intestines to press against the anterior surface of the uterus instead of the posterior surface. The progress now is more rapid. Every effort forces the fundus further back until finally the long axis of the uterus coincides with that of the vagina. Thus we have a complete retroversion which is the first step toward procidentia and prolapses.

No doubt the question has arisen in the minds of some of my hearers as to what bearing the above statements have on a case of complete laceration of the perineum. Of course, here we have no angle at the lower end of the rectum and practically no sphincter.

There is no accumulaton of faecal material dragging on the rectum and consequently no retro-version.

The uterus will sag 'tis true, but this will be the result of intra-abdominal pressure with a defective pelvic diaphram to oppose it, thus placing undue strain upon the ligaments of the pelvic organs.

In substantiation of the foregoing, I have the statement of Prof. Childs of the N. Y. Ployclinic to the effect that he examined quite a number of cases of complete laceration of long standing among occupants of the old ladies' home at that place and found only one in which there was a retroversion.

A study of this subject can only be useful to us only as it enables us to be useful to our patients, which of this particular type are legion.

Now let us see what lessons can be drawn from what has been said. First, partial laceration is a most fruitful cause of constipation. Second, with the uterus tilted backward so that the intestines press against its anterior surface, will repair of the perineum

effect a cure? Assuredly not. Repair is indicated and will remove the cause but not the effect. You may lift the log off the leg of an injured man, you have removed the cause but you have not cured his broken leg. However, you have taken the first step which will make a cure possible.

When we have repaired the perineum, we have simply lifted the log. But there are two points in the procedure that I think deserve special consideration. First, on account of the exhausted or attenuated anterior levator ani fibres, the sphincter has contracted more or less. In order to take the strain off your sutures when the torn muscle ends are brought together, you should dilate this over developed sphincter as a routine practice. It will also enable you to treat the rectal ulcer which is so prone to develop in these cases from pressure by the faecal mass. And lastly, it will aid materially in overcoming the chronic constipation.

The other point to be considered can best be illustrated by reference to the appearance of the sphincter after a long standing complete laceration. The fibres that once formed a complete circle, torn, and no longer opposed, have retracted till they occupy but half the circumference of the bowels.

The same thing can be expected of the torn fibres of the levator ani. We have got to get these fibres if we expect perfect results and we have got to go deep and follow them up if we expect to get them.

Simply building up a fibrous perineal body without restoring the musculature is a parody on surgery.

Of course, advanced procidentia with rectocele or cystocele or both may require special operative treatment, but when all this is attended to, we still have the retroversion. For cases which have existed less than a year I have had good results from the use of pessary. Not-with-standing the fact that they are eschewed by a large part of the profession.

I attempt by the use of the pessary, to push the cervix backward till the fundus drops forward, then by leaving the pessary in position for from three to six months, I expect the muscle fibres in the round ligaments to contract sufficiently to hold the fundus forward. This result can be hastened by Faradism.

For cases of long standing operation will be required before you can effect a cure. Either intra or extra-abdominal shortening of the round ligaments, for those who have passed the menapause ventral fixation is permissable.

Now just a word in closing relative to the recent laceration. In these cases the muscle fibres are not retracted, no scar tissue has formed, thinning of the perineum or dragging on the rectal wall has not developed.

The indications are for immediate repair in all cases unless some serious complication developes.

Any laceration cutting deeper than the mucosa should be repaired. Though it may not impair the muscle sling, it will weaken the buffer, permit of a slight separation of the two sides of the sling and encourage bulging forward of the rectal pocket.

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SYMPTOMS AND FREQUENCY OF CHRONIC APPENDICITIS AND GALL—BLADDER DISEASE—DIAGNOSED STOMACH TROUBLE.

DR. J. R. NEWMAN, Fort Scott, Kansas.

Read at the meeting of the Kansas Medical Society, September 26, 1911.

It is not my intention to present any new symptoms or methods of diagnosis, but to call attention to a few conditions commonly seen in chronic appendicitis and gall-bladder diseases, referable to the stomach and disturbances in digestion.

The word dyspepsia should have been abandoned long ago, for it represents a complex number of stomach symtoms which serve to confuse.

Chronic gastritis should likewise be relegated for the confusion it has caused.

Symptoms referable to the stomach are becoming better understood as advances are being made in the chemistry of digestion and the pathological conditions are revealed at operation and autopsy.

We are beginning to learn that the vast majority of stomach symptoms are caused by pathological conditions in the alimentary canal other than the stomach. These parts are usually the gall-bladder or ducts, liver, pancreas or appendix. An understanding of these conditions are very necessary if we wish to be successful in treating them.

It will at once be seen that by treating these conditions by measure directed to the stomach as a hyperchlorhydria is futile. For example—If we have a disease of the appendix reflexly causing an over-secretion in the stomach, or a diseased gall-bladder, causing pylorospasm by over stimulation of the stomach glands, it can at once be seen how little benefit a patient would receive from a gastroenterostomy.

The relation of chronic appendicitis to stomach trouble has long been understood by some of our best surgeons, but the rank and file of the profession have, no doubt overlooked this condition many times.

McCarty has studied the relations of diseases of the appendix and gall-bladder and declares that many times at operations for stomach ulcers no stomach disease was found other than of abnormal secretions. The disease was located in other parts of the abdomen.

Graham and Guthrie cured 89 out of 115 patients who complained of stomach symptoms and secured great benefit in the remaining twenty by removing chronically inflamed appendices.

Pilser in the study of 271 cases of chronic stomach trouble, upon 100 of which he operated, found 36 was due to chronic appendicitis and gall-bladder diseases combined. In 24 there was pylorspasm, and in two, ulcer of the stomach was found.

Fenwick states that a continuous flow of hyper-acid gastric juice reflexly produced by diseases of some other organ—the appenddix, gall-bladder, pancreas or new growths in the cecum, always excites inflammation in the stomach and is liable to be followed by ulcer and later produces spasm of the pylorus; thus causing intermittent obstruction.

Achlorhydria is attributed by Pilcher to reflex inhibition of secretions by diseased organs elsewhere and a secondary infection with bacteria producing irritation and erosion.

It will be observed, that from these disturbances we may have a hyperacid or a hypoacid condition of the stomach produced by reflex disturbances in some remote organ from this viscus.

The clinical course of these cases may extend over varying periods of time without having an acute attack of appendicitis, while the patient complains of gas, and as he calls it stomach trouble, also of pain in the lumbar region at times, constipation, bloating, and loss of appetite and weight.

If, at the times of exacerbation, you examine the abdomen thoroughly with the legs flexed, there will always be found some tenderness in the region of the gall-bladder or appendix.

If these attacks are repeated for months or years do not deceive yourself into the belief that they are bilious attacks, but make repeated examinations of the abdomen and it will be found that the tenderness about the gall-bladder or appendix is so constant that you will believe that he has the real trouble and finally by watching the results after operations you will soon become convinced of the frequency of this condition.

In conclusion I wish to report a few cases which to me, draw a very clear picture of this condition, i. e.

Mr. D.—male, white—suffered from a supposed stomach trouble for twelve years; decreased from 185 pounds to 153 pounds

in weight; complained of pain in the lumbar region; at times pain after eating; much gas in abdomen; weakness.

After repeated examination of the stomach contents which was hyper-acid and soreness being found in the appendix constantly on very deep pressure, we determined he was suffering from chronic appendicitis.

He was operated on May, 20, 1911. Since that time he has increased in weight to 180 pounds, eats well, sleeps well and suffers no pain.

Case 2—Mr. B. Suffered from attacks of vomiting at various intervals for two years; pain in back; loss of weight.

Stomach analysis showed hyperacidy. Operated on June 1, 1911.

Result—Stomach symptoms have disappeared, normal weight regained and is doing his work without disturbance of any kind.

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CHOLERA INFANTUM.

DR. MAMIE J. TANQUARY, Independence, Kansas.

Read before the Southeast Kansas Medical Society, September 26, 1911.

Cholera infantum is an intense intoxication of the intestinal tract in children, probably of bacterial origin. The direct cause of this disease is yet to be discovered, but unquestionably there is a distinctive toxin generated and in nearly every case we can trace the origin of the disorder to impure milk.

Post-mortem changes of the intestine are few and often undiscoverable. Infants who show signs of bowel trouble early are apt to contract cholera infantum in their second summer.

This disease is characterized by intense vomiting, high temperature, profound prostration, rapid wasting and profuse diarrhoea, and a tendency to an early death.

The stools at first being mucoid, then serous and bile-stained. The serous stools are not practically foul but possess an unmistakable odor which once smelled will never be mistaken for any other disease.

Thirst is intense, the body fluids being drawn upon heavily. The nervous system is greatly impressed; a child stricken with the disease in the morning, presents at night every sign of exhaustion.

Convulsions are not infrequent. The skin is usually cold and clammy while the thermometer shows a rectal temperature of 103 to 105 degrees. Also the sunken eyes, depressed fontanelles and drawn mouth are diagnostic.

Treatment here must be instituted early or all our efforts will be fruitless. The same is also true if proper steps of treatment are not taken. It is not always an easy matter to medicate, as everything given by the mouth is promptly vomited. I attended ten cases of this disease the past summer, eight of them from the beginning of the disease without a death. The other two cases 24 and 36 hours before death, making it too late for any treatment to save them.

Will now try in a general way to give you the line of treatment I follow.

First examine my little patient carefully, counting pulse and taking temperature per rectum. Then give in solution 1-500 gr. hyoscyamine or 1-100 gr. atropine, but I prefer Dr. Candler's calmative for children as it controls vomiting so readily. The formula for which is hyoscyamine 1-500 gr.; oil of cajeput and oil of anise of each gr. 1-67; menthol and monobromated camphor of each gr. 1-67; and acutellarin gr. 1-32. Dissolve one of these tablets in two teaspoonsful of hot water and give from 15 to 20 drops of this solution every 15 minutes until the skin reddens and vomiting ceases.

We next prepare a solution consisting of one pint normal saline, one ounce of olive oil and 15 drops of turpentine, with which I administer a high rectal enema, very slowly, elevating the infants legs and hips, and making pressure on each side of the arms with the fingers. This solution is voided forcibly and in the meantime I massage the abdomen gently but firmly. Following this and while the child is still in the elevated position, I throw high up in the bowel a pint of warm intestinal antiseptic solution(using forty grains of Waugh-Abbott's intestinal antiseptic powder to the pint of warm water. After resting for sometime, the infant is placed in a warm bath of magnesium sulphate solution (one ounce to the quart of warm water). I instruct the nurse or mother to use this bath solution daily, when the temperature begins to rise.

Ice water bag is kept at base of brain constantly. Having done all this, I have 6 or 8 doses of 1-10 or 1-6 grs. calomel given following in one hour with teaspoonful of castor oil.

It may be necessary to repeat this for 2 or 3 days.

Next to be given is a solution of 2 or 3 grains intestinal antiseptic powder, 5 or 10 grains bismuth subnitrate and one half drachm each of liquenzyme (Wyeth's) and water, such dose to be given every two hours until bowels are checked. For sustaining the heart give 1-134 grs. glonoin or strychnia every 3 or 4 hours as indicated. Nuclein is indicated from the first, so five or ten drops is placed in

the mouth every three hours. Some cases the kidneys are inactive, 5 to 10 drops of elix. of saw palmetto and sandal wood in a little water every 2 or 3 hours is sufficient. Warm turpentine stupes are kept applied to the abdomen. Patient must be kept in as thoroughly ventilated room as possible. Give often in small amount cold boiled water. Milk is absolutely forbidden.

When able to tolerate food I depend mainly on barley or albumen water. Later give meat juice, light broth or one of the prepared foods, as Eskay's or Nestle's. In many of these cases we cannot have the services of a trained nurse, but must rely on the efficiency of the mother. I spend more time with this class of cases, instructing the mother how and what to do, but I always give the high enemas myself.

It takes time, but you will never regret it, for you will be sure to save the babies.

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"THE POOR SCHOOL FOR THE POOR BOY" IS IT NECESSARY?

DR. FRANK A. CARMICHAEL, Goodland, Kansas.

Of late I have read with much interest the comments of many of the smaller medical journals on the report of the Carnegie foundation by Dr. Flexner. It is significant that these comments have been almost uniformly in criticism of the report, and Dr. Flexner has been assailed on every hand, by these small "moulders of medical opinion," and his statements have been branded as "arrogant," "unfair," and some have gone so far as to brand them as untrue. As a matter of fact, in facing the task which confronted him in making this report, Dr. Flexner has taken a bold stand and has fearlessly attacked the evils of medical education as they exist today, and has exposed and commented upon them without fear or favor, to the everlasting benefit, not only to the medical profession of the future, but to the millions of sufferers who will come under their ministrations. He has not attempted to flay many of the fake medical institutions as they deserve; he has not held up to ridicule the pretentions of the "private corporation" medical college whose faculty is a stock company and shares in the profit of the concern. Such institutions, without a competent faculty, without hospital facilities, clinical material or efficient laboratory equipment, maintained by "fees from students," are annually distributing their product of incompetents over every state in the union whose state board examination will permit. It is this class of college that seems the paramount attainment of a student to be the

cultivation of a deep chested college yell, a "college spirit" (so-called) and a taste for athletics that may help advertise their college, that is bringing disrepute on the medical profession, weakening the confidence of the laity in its members, and fostering quackery by their incompetence. Admitting that many of our brightest men have been launched upon their career from a small college, and that a good man from a poor school is better than a poor man from a good one, the fact remains that a good man from a good school is far superior, while a poor man from a poor school is a positive menace to the public. Therefore, let us eliminate the poor school, as it has no excuse for existence.

It is always presumptive evidence, when a party to an argument departs from the subject under discussion to indulge in personalities, he has very little premises upon which his side of the argument may be based. Such seems to be the case with those who are making a personal attack on Drs. Flexner and Pritchett.

We may storm and bluster and abuse our opponent but if his arguments are based upon the proper foundation they will stand. A recent writer in adding his humble quota to the general howl could not refrain from eulogizing his alma mater, dwelling feelingly on her many endearing charms, and particularly on "individual instruction to students," which he assumed was impossible in larger institutions. While I was so unfortunate as to spend two years in this so-called medical school in a vain erratic pursuit of medical knowledge, the memory of many weary trips to outlying hospitals, to be confronted by the bulletin, "No clinic today," was too fresh in my memory to permit even a modified thrill of sympathy, and despite the immense advantage of "Individual instruction to students", I note that the report of A. M. A. on the standing of medical colleges in 1904 showed that better than 35 per cent of the product of this school failed to pass the state boards.

The salient facts brought out by the report of the Carnegie Foundation remain to be dealt with. We have no time to consider or admire the halo of good intentions which many of the small and meagrely equipped medical schools present for our delectation and with which the hope to smooth over the flagrant short comings of their institutions. If they could bundle up these good intentions and make a collective bequest of them, there would probably be no further demand for paving material for the lower region for some time to come, but they are about as valuable to their half prepared graduates, as are those of our delinquent patient who presents them to us in lieu of the cash.

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EDITORIAL

If you have not already written your congressman, urging his support of the Owen Bill (Senate Bill No. 1) do not let a minute pass until you do. Urge him in justice to humanity to help the measure pass. Let him know that the health of the United States and its possessions is vitally interested and that it is a duty he owes to his country to support a measure that will be of so everlasting benefit.

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Dr. Charles S. Huffman, of Columbus, Secretary of our State Society, at the earnest solicitation of thousands of friends, lawyers, doctors, business men, miners, etc., has announced his candidacy for Governor. The announcement came too late to say much about his candidacy in this issue, but the March issue will make up the deficiency—it will be a Huffman number. Two of the largest county societies of the state, regardless of politics, have unanimously endorsed Dr. Huffman's candidacy.

Now is the time to send the Journal resolutions from your county society, which should meet at once and give him the encouragement of an indorsement and a pledge to do everything honorable under the sun to secure his election. The Journal wants to print everything of interest concerning Dr. Huffman's candidacy

in the March issue, so if you can help along send in your resolution, and promises of active support so he may know what to count on. It is safe to say that he will get the support of the profession of the state almost to a unit and its dollars to doughnuts that the executive mansion will be occupied after election by a physician—Glory to him.

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Dr. J. J. Sippy, of Belle Plaine, is touring the state in the inteest of the State Board of Health. His work is to see that the law is enforced as to reporting of births, deaths and contagious diseases, and to instruct patients suffering with tuberculosis how to care for themselves and prevent its spread. It is surprising to note the ignorance of the law exhibited by physicians who do not report cases of tuberculosis to the health authorities. If tuberculosis is going to be stamped out it will take the united action of the profession together with the State Board of Health, and will require that the law be enforced, and patients given instruction along the lines of prevention and treatment.

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The annual meeting of the society will be held this year at Hutchinson, May 1-2, 1912. Now is the time to prepare your papers so that when the time comes for their presentation you can answer when your name is called. To often essayists have announced that their papers were hurriedly prepared, which will be a poor argument indeed considering the time which will elapse before the next meeting. As has been stated before it is absolutely necessary that all papers to be published in the Journal must be typewritten and on one side of the paper only. It might also be suggested that it is a wise plan to correct the manuscript before handing in to the secretary for ofttimes articles are so richly endowed with superfluous capitals and mispelled words that the correcting of them by the editor makes his life a burden as well as that of his neighbors. The physicians of Reno County are making elaborate preparations for the entertainment of the society, an announcement of which will be published in the March issue. This year nothing will interfere with the scientific program which will consume a two day session the business of the society to be transacted between times. Now it will be possible to take in the meeting in its entirety with a two days absence and this fact will insure the essayists whose names appear later on the program, a good audience to hear them.

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The opposition of the daily press to the Owen Bill establishing a National Board of Health, seems to be engendered by the League

of Medical Freedom, which the Journal of the American Medical Association so thoroughly exposed in a recent issue. To be able to combat the paid arguments appearing in the daily press, arraigning the Owen Bill and to have a working knowledge of its tenets the following, which is taken from the Bulletin of the American Medical Association is published:

WHAT THE OWEN BILL IS.

Owing to numerous requests for information regarding the Owen bill and its provisions, it seems advisable to summarize the bill briefly for reference, and to state concisely what it is and what it is not. This is all the more necessary since out of the thousands of newspaper clippings received regarding meetings held by the National League of Medical Freedom, interviews by their leaders and canned editorials denouncing the Owen Bill, not one of these newspaper items quoted from the bill itself, neither was the bill read at a single meeting or quoted from verbatim by a single speaker. In fact, it is evident that many of the speakers and writers employed by the League of Medical Freedom have never even read the bill which they are denouncing.

Taking up the bill by sections. Section 1 provides for an executive department known as the Department of Health, of which a Director of Health—to be appointed by the President—shall be the head.

Section 2 provides for an assistant, to be known as the Commissioner of Health, and for the usual Chief Clerk and other department employees and for auditing of accounts.

Section 3 defines the purpose of the Department to be "to foster and promote all matters pertaining to the conservation and improvement of the public health and to collect and disseminate information relating thereto." Provisos carefully safeguard the rights of the states, of private citizens and of all practitioners of healing. This section is the most important part of the bill and should be carefully read in full.

Section 4 provides for the transfer to the new department of (a) the Public Health and Marine-Hospital Service from the Treasury Department; (b) the Bureau of Chemistry (in part) from the Department of Agriculture; (c) the Division of Vital Statistics, of the Bureau of the Census, from the Department of Commerce and Labor. The President is also authorized to transfer any part of any other department engaged in public health work, except the Medical Department of the Army and the Bureau of Medicine and Surgery of the Navy. It is also provided that all the powers, functions, records and appropriations of any bureau transferred, shall be transferred with it.

Section 5 provides for eight bureaus: (a) Sanitary Records, (b) Child Hygiene, (c) Vital Statistics and Publications, (d) Foods and Drugs, (e) Quarantine, (f) Sanitary Engineering, (g) Government Hospitals, (h) Personnel and Accounts.

Section 6 provides for temporary exchange of employees with other departments.

Section 7 provides for an advisory board of seven specialists to advise with the Director. This board already exists as the advisory Board of the Hygienic Laboratory.

Section 8 authorizes the Director to call a conference of the health authorities of all the states when deemed advisable. This power is now possessed by the Surgeon-General of the Public Health and Marine-Hospital Service.

Section 9 confirms the existing functions of the three bureaus transferred.

Section 10 provides for an annual report to Congress.

Section 11 provides —— dollars to carry out the purposes of of the act.

Section 12 is the usual repeal of all conflicting acts.

Section 13 provides that the act shall take effect July 1, 1912.

WHAT THE OWEN BILL IS NOT.

1. The bill was not originated by the American Medical Association or by any of its officers or members. Senator Owen's declaration on the floor of the Senate is sufficient proof of this fact. The American Medical Association has for twenty years urged the passage of such a measure. When Senator Owen introduced his original bill (S. 6049, now S. 1) the Association naturally endorsed it and has continued to do so as it will any measure which is for the public good, but to Senator Owen alone belongs the credit of originating this bill and for urging its passage.

2. The passage of this bill will not and cannot create a "medical trust." Every intelligent lawyer knows that the right to regulate the practice of medicine, as well as other trades and occupations, lies in the state and not the national government. No law which Congress can pass will or can have any effect on the practice of medicine in the states. (See Freund, Police Power, also Senator Owen's reference to Supreme Court decisions on this point, on page 88 of this pamphlet.))

3. The passage of this bill will not and cannot interfere with the right of anyone to select any form of treatment, or any kind of healer or attendant he may desire This bill has nothing to

do with the treatment of individual patients. It provides for the study of diseases in laboratories, by means of chemical, bacteriological and biological investigations. It contains no provision whatever for the treatment of any individuals by any one.

4. The passage of this bill will not force any one to submit to any treatment he does not desire. As stated above and as a reading of the bill will show, this measure has nothing to do with the treatment of individual patients. The provisions in Section 3 fully safeguard the rights of every citizen, although this is entirely unnecessary, since Congress has no power to make any one accept any form of treatment for any disease. Congress may make quarantine provisions, detaining persons suffering from certain diseases until they recover, in order to prevent epidemics. The states may make their similar provisions. But neither Congress nor the states have any power to compel any person to take medicine or form of treatment they do not desire.

SUMMARY.

We have seen what the bill is and what it is not. A careful reading of the text will show that the statements made above are correct. The bill will not do any of the things its opponents claim it will do. It simply will transfer to a new department three existing bureaus and coordinate their work by bringing them together. A simple matter, and one incapable of doing injury to anyone. Why then has so much effort been made to prevent its passage? Why have the Homeopaths, the Eclectics, the Osteopaths, the adherents of countless sects, the Christian Scientists, all been duped into believing that this bill affects their interests? Why has the battle cry of sectarian oppression been raised? Why has a great national organization, claiming 200,000 members, been created? Why is an enormous campaign fund being raised to defeat this bill and to defeat for reelection, every man in Congress who favors it? Surely there is no danger to any interests in transfering the Public Health and Marine-Hospital Service from the Treasury Department to a new department. Certainly the Division of Vital Statistics is harmful to no one, whether in the Department of Commerce and Labor or in a new department. It is not to oppose these that speakers, press-bureaus and paid agitators are working day and night. But the Bureau of Chemistry of the Department of Agriculture! That's different! That is the Bureau that is headed by Dr. Wiley who enforces the Food and Drug Act (when he gets a chance). For years through political pull and personal influence by obstruction and delay, the "patent medicine," proprietory medicine and adulterated food makers and sellers have hampered

Dr. Wiley in every way. The recent investigation in Washington proved this. As long as Dr. Wiley is a part of the Agricultural Department, he can be annoyed and hampered. But suppose he were transfered to a new department which was run for the protection of the people and not for commercial interests? What wouldn't he do to the adulterators, the lying advertisers, the manufacturers who use rotten and filthy material in their products and the men who swindle and cheat the sick? What has been done so far wouldn't be worth mentioning in comparison to what Dr. Wiley and his bureau would do, if he were transfered to a department where he was not and could not be hampered by politics or commercial influence. And the men and interests whose fat profits he has affected know this.

The influence back of this entire compaign against the Owen Bill is those advertising agencies, which make a specialty of advertising of patent and proprietory medicines and adulterated food products. These men have joined with their patrons, the makers of these products, to prevent the passage of any bill that will give Dr. Wiley any more power. Not daring to fight in the open, they have persuaded the sectarians, the faddists and enthusiasts that their rights are endangered by a bill which does not create anything that does not exist, that does not increase the power or authority of any officer or employee of the government and which will have no effect on any individual, except to give us all purer food, purer streams, and more knowledge. If by arousing sectarian suspicion and jealousy and by deceiving the people, this bill can be defeated the people will suffer and the dishonest manufacturer and advertising agent will rejoice.

PREVENTATION AND NOT TREATMENT.

An osteopathic association recently adopted a resolution favoring a national department of sanitation, but opposing a national department of medicine. This is encouraging, and this osteopathic association is to be congratulated on its broad-mindedness and perspicacity. We did not know, however, that anyone favored a department of medicine, or that there had been a suggestion that one be established. The Journal has again and again insisted that the sectarian adherents were exciting themselves unduly and needlessly. A national department of health would be charged with the work of studying the cause and methods of preventing diseases. It would have nothing to do with the treatment of individual patients or with the practice of individual physicians. Those who

object to the Owen Bill on such grounds are incapable of distinguishing between the scientific study of disease in the abstract and the care of the patient suffering from the disease. The first is an important duty. The second is a matter of personal choice. The vague and awful charges of "establishing a state school of medicine," "medical tyranny," perpetuation of a medical trust," interference with personal liberty," etc., are made either through ignorance or through a desire to mislead the public as to the real purpose of such a measure.

Let it be repeated again: Congress has no power to pass any law interfering with the practice of medicine in the states. Neither Congress nor any state legislature has any right to compel any sane adult to take any form of treatment against his will. The Owen Bill does not create a single new bureau or division. It simply collects, in a single department, certain existing bureaus and divisions having functions bearing upon public health. It authorizes the establishment of laboratories and the employment of scientific experts to study disease as Koch studied tuberculosis, as Carroll and Lazear and Agramante studied yellow fever, as Stiles and Ashford studied hookworm, as Ricketst studied mountain fever, as Flexner is studying cerebrospinal meningitis.

Have any of these men interfered with personal liberty? Has not the victory over yellow fever, as the result of the work of the Army medical officers, released the entire south from the fear of epidemics, the tyranny of the shot-gun quarantine, the periodic suspension of business and the loss of millions of dollars each year? Has the discovery of the hookworm and the possibility of removing this infection and its results, given new hope to the South of the solution of its labor problem and its industrial development?

Has Gorgas, in the Canal Zone, trodden on the rights of any one? Yet America is building the canal, where France failed, because applied scientific knowledge is guarding the workman from disease and keeping him alive to do his work. It is about time that the American public understand that the stock objections to advanced sanitary regulations are based on ignorance and misconception of both the law and the facts. A national department of health, like our state boards of health, would be for the studying and preventation of disease and the advancement of public health and not for the treatment of individual patients, or for the regulation of the practice of medicine.—(Editorial, Journal of the American Medical Association, Nov. 11, 1911.)

WHY THE OWEN BILL SHOULD PASS.

It may, with good reason, be asked: Why, if the Owen Bill is so simple and the changes effected by it so slight, is its passage of any great importance to the public? Why should the three bureaus effected be transferred and what advantages will result from the change? These questions are pertinent and timely. Fortunately, the answer is simple. The three departments affected are the Treasury Department, in which is the Public Health and Marine-Hospital Service; the department of Commerce and Labor, includes the Bureau of the Census with its Division of Vital Statistics, and the Department of Agriculture, with its Bureau of Chemistry. The keynote in the management of all three of these departments is material gain, commercial advantage. This is proper. These departments could not and should not be run on any other basis. But, in considering the health of the people, there is another factor—humanitarianism. The reduction of disease and death will save money, it is true, but it will also save what is far more precious—human lives. The place for bureaus concerned in life-saving is in a department where humanitarianism is the predominating motive. So long as they are in departments that are material, commercial influences prevail, they will be hampered, and to a certain extent nullified! Witness the effort of the Treasury Department to suppress the findings of the Marine-Hospital surgeons in the case of the bubonic plague in San Francisco. Witness the efforts of the Department of Agriculture to hamper and discredit Dr. Wiley. Even in the Department of Commerce and Labor, statistics on iron and steel, coal and copper are more highly esteemed than figures on death and disease. Health activities have no place in departments guided by material considerations. In case of any conflict of objection, the first question asked is: Will this hurt business? The only place for health work of the government is in a new department of its own, where human life will come first, and business considerations will take a second place. This is the main reason for the passage of the Owen Bill. But this reason is sufficient.—(Editorial, The Journal of the American Medical Association, Jan. 13 1912.)

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EDITORIAL CLIPPINGS.

In his annual report the Secretary of the Navy, announces that venereal diseases continue to be the most potent factor of damage to the Navy. A system of prophylactic treatment is being carried out, which he believes will be more generally used if his recom-

mendation be adopted, of forfeiture of pay during disability from disease of venereal origin.

The results obtained from typhoid vaccination have justified the recommendation to make it compulsory with all officers and enlisted men under 45 years of age. A similar order was issued several months ago by the War Department, and we understand that Secretary of the Navy, Meyer, has already made typhoid prophylaxis a general order.

It may be interesting to note that the Naval Hospital, at Las Animas, Col., the results obtained from the treatment of tuberculosis with injections of mercury have not been such to justify the belief that the mercurial treatment is a specific in the treatment of tuberculosis.

In view of the efficient service rendered by the hospital ship, "Solace," during the past year, it is recommended that a hospital ship should accompany each fleet. In the Atlantic Fleet and its auxiliaries the personnel probably exceeds 14,000, and no city of that size would be without at least one hospital in addition to numerous physician's offices for consultation and treatment of diseases of lesser importance.

The report is most interesting, and, with the recommendations offered, indicates an intelligent study and inspection of the work done by the Medical Corps of the Navy, as well as what remains to be accomplished.—Virginia Medical Semi-Monthly.

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BEE STINGS DISCREDITED.

The treatment of chronic articular rheumatism by means of bee stings, recently highly praised, would appear to have suffered a reverse. The therapeutical pendulum is swinging back nihilistically. T. Duncan Newbigging, a Scotch physician, reports in the Practitioner for January, 1912, that he believes the bee sting method to be nothing short of mere humbug. He has tried it repeatedly on himself. He owns to the fact of being an extensive bee keeper, and is frequently stung, "sometimes to a degree that is alarming." Fifty stings a day would not inconvenience him, yet he suffers severely from muscular rheumatism. This is not because he counteracts the effects of the stings by his mode of life, which is the simpliest. As a consolation for the failure of the bee method he contents himself with frequent sponging of the whole body, except the face, with dilute acetic acid, a less heroic procedure and one, judging by the relief obtained, far more efficacious.—New York Medical Journal.

SOCIETY NOTES.

Reno County Medical Society at its meeting in Hutchinson, elected Dr. Clemens Klippel, president; Dr. Hunter J. Duvall, vice-president, and reelected Dr. William F. Schoor, secretary-treasurer, all of Hutchinson.

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At the annual meeting of the Cherokee County Medical Society, the following officers were elected: Dr. Claude Lowdermilk, Galena, president; Dr. William N. Johnson, Columbus, vice-president; Dr. Albert A. Shelly, secretary-treasurer.

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Arrangements are being made for the spring meeting of the Medical Society of the Missouri Valley, which will be held in Colfax, Iowa, on March 21st and 22nd, under the presidency of Dr. J. M. Bell, of St. Joseph, Mo. In addition to a scientific program of great interest, plans are in progress for a series of clinics to be held at Des Moines on Saturday, March, 23. An elaborate programme of entertainments is also being arranged for the visiting members and their friends. Dr. Granville N. Ryan, of Des Moines, Iowa, is chairman of the committee of arrangements.

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The Sumner County Medical Society at a meeting held January 18th, at Wellington, elected the following officers:

President: Dr. Emery Trekel, Milan; vice-president, Dr. A. R. Hatcher, Wellington; Censor, Dr. S. W. Spitler, Wellington; secretary-treasurer, Dr. T. H. Jamieson, Wellington; Dr. H. F. Wyndman read a paper on Pyelitis in Children. Light refreshments and a smoker followed.

T. H. JAMIESON, Secretary.

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February Program of the Harvey County Medical Society.—

Dr. L. T. Smith, "Chronic Gastritis," Discussion, Dr. E. E. Wuttke.

Dr. J. W. Graybill, "Gastric Ulcer," Discussion, Dr. J. M. Sutton.

Dr. J. T. Axtell, "Gastric Cancer," Discussion, Dr. H. A. Seehorn.

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At the annual meeting of the Crawford County Medical Society held in Pittsburg, December 12, 1911, the following officers were elected for 1912:

President, Dr. R. B. Gibb, Pittsburg; vice-president, Dr. L.

Miesse, Yale; secretary-treasurer, Dr. Hugh B. Caffey, Pittsburg; delegate, Dr. H. H. Bogle, Pittsburg.

The meetings are held the first Tuesday of each month and arrangements are being made to secure the auditorium of the new Carnegie Library as a permanent meeting place.

HUGH B. CAFFEY, Secretary.

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At the regular annual meeting of the Saline County Medical Society, the following officers were elected for the ensuing year.

President.—Dr. J. W. Neptune. Vice-president, Dr. O. R. Brittain. Secretary, Dr. O. D. Walker. Treasurer, Dr. C. D. Armstrong.

Censors.—Dr. H. W. Moses, and Dr. W. S. Harvey.

Delegate to State Meeting. Dr. J. H. Winterbotham; alternate, Dr. H. M. Moses.

After the program of the evening, the society was invited to a nice supper by the retiring president, Dr. J. H. Winterbotham.

O. D. WALKER, Sec'y.

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Sterling, Kas., Jan. 26, 1912.

To the Kansas Medical Journal:

The Rice County Medical Society at its annual business meeting, elected the following officers for the year 1912: President, Dr. L. E. Vermillion, Lyons; vice-president, Dr. W. E. Currie, Sterling; secretary-treasurer, Dr. J. M. Little, Sterling; censor for three years, Dr. E. C. Fisher, Lyons; delegate to the state society, 1912, Dr. M. Truehart, Sterling; Dr. Truehart was chosen to represent the society at the state meeting in May and read a paper.

The society has been following the post-graduate course of the A. M. A. and is in a very satisfactory condition.

J. M. LITTLE, Sec'y.

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At the Annual Banquet of the Wyandotte County Medical Society, held at Kansas City, Kansas, January 30th. Dr. Charles S. Huffman was guest of honor. He announced his willingness to become a candidate for Governor and the ovation which he received when the announcement was made by the president of the society, Dr. Geo. M. Gray, was one which left no doubt as to the feeling the doctors of Wyandotte County have for his candidacy. A resolution presented by the Hon. J. K. Cubbison "that we urge Dr. Huffman to become a candidate and pledge him the united support of the physicians of Wyandotte County," was carried with great enthusiasm. At the banquet covers were laid for one hundred

guests and toasts were responded to by the following: Invocation, Dr. S. S. Glasscock; Dr. Geo. M. Gray, toastmaster. The Wyandotte County Medical Society—Its Early History, Dr. William F. Fairbanks. I am a Doctor—Why? Hon. Maurice T. Alden. I am not a Doctor—Why? Hon. J. K. Cubbison, A Lawyer-Senator. Dr. Charles S. Huffman, A Doctor-Sentaor. The Sumner High School Glee Club and Riley's Orchestra furnished music and Mr. Don Turley performed some feats in legerdemain which mystified the banqueters.

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At the meeting of the Wyandotte County Medical Society held January 16th., Dr. R. C. Lowman presented a paper on Ischæmic Myositis, and Dr. C. C. Nesselrode presented some pathological specimens.

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NEWS NOTES

Drs. D. S. O'Brien and W. H. Cook will shortly open a modern hospital at Beloit, Kansas. The hospital will be open to the reputable physicians of Beloit and its vicinity. The capacity will be ten beds.

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Dr. Chas. H. Mayo of Rochester, Minn., who was operated upon for appendicitis in New York, December 16th and one week later for acute cholecystitis, with gall-stones, has recovered.

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The State Board of Medical Examination and Registration held a meeting at Topeka, February 13. The board announced that hereafter all examinations will be held at Topeka.

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The State Board of Control of Kansas has selected a site one and a half miles west of Larned for the new State hospital for the insane, which was authorized by the 1911 legislature, and which will cost $100,000. The board now has an option on about eight hundred acres of land, which will be used as grounds for the institution, as work in the open air will be a feature of the treatment. No plans for the buildings have been drawn as yet, but it is understood that the hospital will be built on the cottage plan, with four or five cottages to start with, and additions made when they are needed.

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Dr. R. A. Light of Chanute, has returned to the practice of medicine after a lapse of 3 years, during which time he was engaged in the banking business.

The epidemic of meningitis which has been prevalent in Texas as far south as Houston and Austin, centering chiefly in the vicinity of Dallas, is reported to be under control.

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Dr. Jacob Geiger of St. Joseph, Mo., was guest of honor at the annual banquet of the St. Joseph, Buchanan, Andrews county medical society held recently. The society presented him with a loving cup.

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Dr. Lewis S. Harvey, after a long absence from business, has re-entered practice with his brother, Leland H. Harvey, of Council Grove, Kansas.

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The National Confederation of State Medical Examining and Licensing Boards will hold its 22nd annual meeting in Chicago, Illinois, on Thursday, February 29th, 1912, at the Congress Hotel.

The subjects to be considered at this meeting will be : "The good a federation of medical boards can do. What should be the qualifications for membership in a federation of medical boards? Methods of conducting state licensing examinations. Medical school equipment and state board license examination. The organization of a federation of state medical boards.

The topics to be presented are practical to all those interested in medical education and a federation formed upon lines to be suggested will, necessarily prove fruitful.

An earnest and cordial invitation to this meeting is extended to all members of state medical examining and licensing boards, medical teachers, delegates to the Council on Medical Education of the A. M. A., and all those interested.

The officers of the Confederation are President, Charles A. Tuttle, M. D., 196 York St., New Haven, Conn; secretary-treasurer, Geo. H. Matson, M. D., State House, Columbus, Ohio.

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Reviews.

Diarrhea in Infants.—Lereboullet, in *Paris medical* for December 2, 1911, praises a plan of treatment devised by Weill, Lumiere, and Pehu. A ten per cent. solution of sterilized gelatin in physiological saline is made into a jelly and kept in a closed tube. Before each feeding, the solution is melted on a water bath and ten cubic centimetres of it are poured into the bottle containing the milk, At the fourth or fifth stool, after the beginning of the treatment, the feces show marked improvement, the odor disap-

pearing and the color and consistence approximating the normal. The gelatin facilitates digestion of the milk by causing the clots to break up into fine particles, and as a result the stools are rendered more solid in consistence. The measures gives specially good results in light forms of diarrhea. The necessity of stopping milk entirely may thus be avoided. Similarly, when feeding with milk is resumed, after suspending it for a time in the more pronounced cases, the use of gelatin is indicated. In severe diarrheas of choleraic type, however, gelatin is of little value, as it has no power to counteract the infectious process present.—New York Medical Journal.

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The Real Action of Caffeine.—In the original columns of the January issue of the Therapeutic Gazette will be found two interesting contributions upon the physiological action of caffeine, one by Dr. Hollingworth, of Columbia University, New York, and one by Dr. H. C. Wood, Jr., of the Medico-Chirurgical College, Philadelphia. These articles throw a new light upon the actual effects of this substance. Heretofore it has been regarded as a stimulant which increased physical activity as well as mental activity by enabling the individual who took it to call upon his reserve energy with the ultimate result that he would be a nervous bankrupt. Dr. Hollingworth's investigation, which was carried out independently of that of Dr. Wood, indicates that if a man gets his ordinary amount of sleep and food he can, under the influence of caffeine, do more mental work and certainly do it more easily than when this drug is not taken. Dr. Wood's experiments also show that the frog's muscle can do more work under the influence of caffeine than without it. In other words, it would seem that this drug acts as a lubricant, so to speak, so that more work can be accomplished with no more work expenditure of tissue or energy than is ordinarily the case. In other words, its use does not cause exhaustion of the nervous and muscluar systems, but enables them to act with greater ease.

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Urinary Findings in Cancer.—Salkowski, in Berliner Klin. Wochenschrift, referred, in a previous communication, to an unusual division of the nitrogenous constitutents of the urine in patients suffering with cancer. Kojo, working in Salkowski's laboratory, has devised simpler methods of examination, and with these a few urines have been examined. The method (details of which are to appear in a subsequent paper) employs the following manipulations: The phosphates and sulphates are first removed from

the urine by precipitation with alkaline barium chloride solution (2 volumes of baryta water and 1 volume of 10 per cent. barium chloride.) The filtrate obtained from 100 c. c., of urine, after accurate neutralization with acetic acid, is precipitated with subactetate of lead; the precipitate is collected quantitatively, washed thoroughly, and its nitrogen content is determined (collodial nitrogen.) The percentage of N in the precipitate, taking the total N as 100 per cent, is calculated. The average of the urines of ten healthy individuals was 1.22 per cent of the total N; in ten cancer cases, 3.03 per cent. The report is only preliminary. It remains to be determined whether such increase is characteristic of cancer alone.—Medical Standard.

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Facial Convulsions.—A. Gordon, Philadelphia, (Journal A. M. A., January 13), describes the three types of convulsive movements of the face—tic, facial spasm and epileptic twitchings. As regards the latter, they are usually associated with generalized epilepsy or with focal epilepsy of the same side. In some cases they may be confused with tic and facial spasm, but the most important differentiating feature is in the successive and progressive contraction of the different facial muscles instead of a simultaneous contraction of an entire half of the face seen in facial spasm of non-cortical nature. Facial tic is characterized by a sudden abrupt contraction of one or several muscles, always the same but not corresponding to a well-defined nerve region. It has a tendency to spread and invade other functions and can be controlled to a certain extent by the patient's will. It is a psychic malady and the patient's mental state can be used to control and inhibit it. It is largely a habit neurosis and its chief characteristic feature lies in exaggeration or disfigurement of physiologic gestures or mimicry. In true facial spasm, on the other hand, there is no tendency to reproduce physiologic acts and the convulsive movements are limited to the well-defined areas of nerves. It occurs also in sleep and is incapable of being voluntarily controlled. Its pathogenesis is still somewhat in doubt and it is entirely different from the convulsive movements of the douloureux, which are the result of irritation of sensory fibers of the fifth nerve. While in the majority of cases the spasmodic contraction of the face is caused by peripheral irritation, organic lesions higher up may be possible factors, as some of the clinical observations indicate. As regards treatment of facial epilepsy, it is that of the disease in general and is not very satisfactory, excepting in cases of specific origin. Tic

requires also general treatment and careful mental hygiene and training. In facial spasm the use of alcohol injections into the facial nerve sometimes gives satisfactory results. The operation is not difficult. The injection should be made into the nerve where it comes out of the stylomastoid foramen, but it may not always be easy to hit the exact point. A facial palsy must follow immediately if the injection is successful, and this fact should guide the operator. Repeated injections of alcohol are not dangerous. Five minims of an 80 per cent. solution is the amount required. This treatment is only useful in genuine facial spasm, of which two successfully treated cases are reported.

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Tetanus Prophylaxis.—O. Berghausen and C. E. Howard, Cincinnati (Journal A. M. A., January 13), reproduce the instructions given to interns and nurses in the Cincinnati Hospital as regards the treatment of punctured, lacerated and penetrating wounds, especially these from giant crackers and blank cartridges. They include thorough cleansing and removal of foreign matter, cleansing the wound with 5 per cent. phenol-hydrochloric acid solution, enlarging the opening if necessary and using a general anesthetic if called for, then packing the wound lightly with gauze soaked in the phenol-hydrochloric acid solution, dressing the wound, and changing the dressing daily. Immediately after the first dressing 1,500 units of antitetanic serum are given subcutaneously. This treatment has been found sufficient, but special care must be taken to remove all foreign bodies, especially in case of blank-cartridge wounds. They quote from Sir D. Semple as to the existance of tetanus spores sometimes in the tissues of persons apparently in good health, which are liable to be called into action by local suppuration or the conditions of great fatigue or exposure to cold. Such spore carriers are in great danger of tetanus whenever the site of the spores becomes a medium at all favorable for the growth of the germ. He advises the use of antitetanus toxin as a valuable prophylactic when using quinin hypodermatically. Serum reactions were noticed in several cases and for their prevention atropin sulphate (gr. 1-1000 to 1-120 three times a day; less in children) was given subcutaneously, especially when numerous injections of serum were made in developed tetanus. Amelioration or prevention of the reactions was thus obtained. The author gives a list of the wounds and of the number of cases of each, ninety-six in all, in which the serum was used as a prophylactic, and a list of cases in which it was not used, with the results. In these last cases the serum was

employed only after the disease developed, and one of the two patients who recovered received as much as 50,000 units in one case. They remark that, although cases with a short incubation period offer the least hope, they are not necessarily fatal. One patient was seen two days after the symptoms of tetanus had developed, yet these mostly disappeared after one week's careful treatment. The subcutaneous administration of phenol, 2 per cent. solution, causes the early appearance of albumen in the urine and a possible damage to the kidneys must be considered. In the future, the authors say, they will follow such injections by the the rectal administration of a hypertonic neutral salt solution to limit, if possible, this damage.

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Iodin in Small-Pox.—C. S. Rockhill, Cincinnati (Journal A. M. A., January 27), reports that he has used a 10 per cent. iodin and 90 per cent. glycerin mixture painted over the pustules of small-pox during the past year with very satisfactory results. It dries the pustule, causes absorption of the toxin and arrests the destruction of tissue, thus preventing the usual disfigurement. It has shortened the duration of the hospital stay, from twenty-five or thirty days under the old treatment, to eight to fifteen days. The pustules on the face may be opened with a sterile instrument and touched up with tincture of iodin. Eighty-five patients have been treated by this method within the past year, with 100 per cent. of recoveries and an average stay in the hospital of twelve days.

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Cerebrospinal Meningitis.—The recent discovery of the fact that the natural habitat of the organism of cerebrospinal meningitis is in the nose and throat is considered by H. T. King, New Orleans (Journal A. M. A., February 10), to be the most important contribution to our knowledge of the prophylaxis of the disease. With this fact also should be considered the discovery that the disease is carried from individual to individual, often by healthy carriers. The theory of direct extension from the nose and throat to the brain is untenable. The blood-route must be the one followed. In many cases the organism has been found in the blood and it seems to have a special affinity for the meningeal tissues. There must be, however, some lowering of tissue resistance or increase of virulence of the organism, and the cause of this may, in some cases, be a trauma. The disease is undoubtedly transmitted directly from individual to individual and the number of persons carrying the infection is much greater during an epi-

demic than the number of patients. King estimates that nearly one-fourth of all individuals of the infected locality may be carriers of the disease without apparently showing any serious symptoms. Only occasionally do they present signs of a nasal pharyngitis or slight meningococcal infection. There are some persons who probably carry the germs permanently and perpetuate the disease. Up to the present there has been no absolutely efficacious means of causing the disappearance of the germs in the carriers, but the rigid observance of certain precautions would limit the extent and severity of epidemics. The first essentials for this are: 1. The earnest cooperation between the people and the health authorities in enforcement of all necessary health regulations. 2. The detection and isolation of healthy germ carriers. 3. Efforts toward rendering them harmless. Thorough sanitary inspection is necessary and attention to soil pollution, especially in rural districts. Particular efforts should be made to destroy all germ-carrying parasites and vermin. Circulars of information should be distributed, school inspection should be thorough and popular lectures will also be useful. A carrier once recognized should be put under the care and observation of the health authorities and treatment directed toward disinfection of the nose and throat. All carriers should be inoculated with the antimeningococcal serum. The results should be constantly tested bacteriologically and oral and nasal hygiene be made a routine, not only with, but with others. Fomites, such as vessels, spoons, handkerchiefs, etc., which have become infected should be thoroughly sterilized or destroyed and special directions as to spitting, sneezing and coughing be given to all carriers of germs. By these means we may hope to minimize the effects of the disease when it occurs.

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Salvarsan in Pernicious Anemia.—A. Friedlander, Cincinnati (Journal A. M. A., February 10), reports a case of typical pernicious anemia in the blood-picture with great numbers of megaloblasts and red cell-count of 887,000. The patient had taken large quantities of iron and arsenic in the previous treatment. A gluteal injection of 0.3 gm. salvarsan in sesame oil was given Oct. 10, 1911, and this was repeated October 18. This was followed by hypodermic injections of 1 gr. cacodylate of iron given on alternate days, twenty-seven doses in all. A meat-free diet with large amounts of buttermilk was administered. The patient's improvement was rapid and she now presents merely the blood-picture of a mild anemia, the red corpuscle count being 3,200,000

on December 21, last. The change after the use of salvarsan was very striking.

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Treatment of Gout.—A. E. Tussig (Interstate Medical Journal, December), in a review of the recent literature of gout brings attention to several theoretically interesting and practically valuable points. Gout is no longer regarded as due to an over production of uric acid, but rather to a faulty elimination of that substance. Uric acid is derived exclusively from the disintergration of substances contained in the nuclei of cells, whether these be contained in the ingested food or in the cells of the body which have undergone destruction. In gout the ability to handle uric acid seems diminished in every respect. The result is an accumulation of mono-sodium-urate in the blood until sooner or later the limits of solubility are passed and there is a deposit in crystalline form of the urate in the subcutaneous tissues or joints. This retention of uric acid may be watched in the urine. Normally when a person is given a large amount of uric acid forming (purin) food, there is a prompt and rapid elimination of urates in the urine. In gout this elimination is tardy and sluggish. At only one time does the urate content of a gouty patient tend to become high, and that is during the acute attack. These characteristics are very valuable in diagnosis. Taussig believes that the use of colchicum should be discontinued, as it does no permanent good and may do considerable injury to the heart. A purin-free diet is the only rational treatment to be employed. The potassium salts in potato and rice make these articles valuable in the dietary. Treatment with large doses of hydrochloric acid, from 50 to 90 drops of the concentrated acid daily, well diluted, has been found of immense value in the hands of some men. Kionka and His have recently used radium emanation with wonderful success, and declare that the beneficial effects of natural mineral waters are in direct proportion to their radio-activity. The action of the radium seems to be in its ability to change the less soluble urate salt into the more soluble, and thus facilitate its elimination.

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OBITUARY,

Nathan D. Tobey, M. D., University of Maryland, Baltimore, 1869, an ex-member of the Saline County Medical Society, Golden Belt Medical Society, first president of the Saline Hospital Association, was instrumental in the establishment of hospital

in Salina, Kans. Practiced his profession at Hagerstown, Maryland; Clifton, West Virginia; Salina, Kansas and vicinity since 1883; at one time editor Salina Herald. Died at Vaughn, New Mexico, January 19, after brief illness, aged 74.

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Robert Schuler Black, M. D., Medical College of Indiana, Indianaoplis, 1880; once president of the Kansas Medical Society and the Franklin County Medical Society; died at his home in Ottawa, January 12, from diabetes, aged 61. At a special meeting of the Franklin Medical Society, January 13, resolutions were adopted testifying to the excellent personal and professional qualities of Dr. Black.

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William M. Ewing, M. D., Medical College of Ohio; Cincinnati, 1873; for thirty years a resident of Ottawa, Kan; died at the home of his daughter in Des Moines, Ia., January 16, from senile debility, aged 80.

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MISCELLANEOUS.

Medical Ideals.—W. W. Anderson, Newport, Ky. (Journal A. M. A., January 27), asks who better than the physician can have high ideals, as every advance in his science is pushed by the profession often to its loss and against bitter opposition. No other calling or profession has such a record of unselfish devotion to humanity. He points out that the physician foregoes the chances of becoming rich, and there is hardly one that could not double his income if he adopted the ethical code and practices accepted in the general business world. The every-day practice of medicine, he says, is eminently fitted to make the most of any man who will give himself devotedly to the work for its own sake. The great men in medicine were not born to greatness, but they had great problems to solve and solved them by their energy and devotion, There is still a great field for advancement in medicine and improvement in our practice, and the world has a right to expect it from us. Only in the department of major surgery is the medical art following closely in the footsteps of science, because its results are constantly reviewed and criticized by the profession, because it commands a fee that supplies the means for good work, and because of its limited field which can be cultivated. The same is true also to a certain extent in the other specialties, and while a broad general knowledge is always necessary, the times demand even more insistently that, while the

physician broadens his general vision, he should narrow his field of work. Every physician should do some specializing. The whole field is too broad for any one man to cover. He ought to serve his patients in every case to the best of his abliity, but he can do best if he will also devote a portion of his study to special subjects, Consultations ought to be more frequent, and they would be if each physician would take up some line in which to be the neighborhood expert. The greatest opportunities are waiting for the general practitioner who first sees 95 per cent. of all the patients. Only let him not try to grasp everything or lessen his efficiency by trying to do too much. Where his knowledge and skill are not up to the needed standard, let him call in consultation his fellow-practitioner best qualified in that line.

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Suicide of Surgeon After Operation.—An incident is reported in the Adeverul (Bucharest, Roumania) which is full of pathos and interest for medical men. It appears that a Dr. C. Lascul was driving past a farm when a poor woman ran out of a cottage and begged him to see her child, who was very ill. The doctor after examining the patient came to the conclusion that he had diphtheria, and advised that he should be removed to the town hospital. The parents refused to part with the child; and Dr. Lascul was compelled to do the best he could for him in the rude cottage. Calling next day, he found that it was necessary to perform an operation—presumably tracheotomy—and single-handed he essayed to carry it out. Something, however, went wrong during its performance, and though he gave up his engagements and remained with the child some time, he saw that it was impossible to save the child's life. This unhappy occurrence so much affected his mind, that he burst into tears and reproached himself with being a murderer. He then hastily wrote a note, and putting it under the ink-bottle, asked the mother for a drink of water. No sooner had she left the room to fetch it than the report of a revolver was heard, and on hurrying back she found Dr. Lascul dead with a bullet-wound in his temple. The note read as follows: "Pardon a young doctor his involuntary error, by which he has deprived you of your child." Soon afterward the child died also.—Journal A. M. A.

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Medical Expert's Testimony.—The criticism of medical expert testimony persists. Nothing has been done, says the New York Times for January 12th, to regulate the introduction of such testimony in the courts so that the scandals of bought and biased

opinions might in future be obviated. But the New York Academy of Medicine still hopes that the Legislature may pass its bill, as introduced March 9, 1909, amended in 1910, and reintroduced at its recent committee meeting for introduction at the present session. The nub of the bill is the requirement that the Supreme Court Justices shall designate in each judicial district at least ten, and not over 120, physicians who shall possess the minimum qualifications, as formulated by the academy 's resolutions adopted on January 3rd. This requirement of fitness would largely prevent the muddling of the juror's minds by a volume of conflicting testimony given by incompetent "experts." The bill provides further that the designation of experts may be revoked "without notice or cause shown" and any vacancy may at any time be filled by the justices. Moreover, the experts shall be subject to full examination and cross examination like other witnesses.—New York Medical Journal.

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CLINICAL NOTES

The Value of Coley's Toxins in Sarcoma.—What conclusions can be drawn regarding the value of the mixed toxins as a remedy in sarcoma? Can it be called a specific in the treatment of this disease? I think every unprejudiced observer will agree in denying any such power to this remedy because comparatively few persons are cured by its administration—the vast majority—at least 90 per cent. of the cases are uninfluenced by its use.

Is it a promising remedy—one that gives evidence of increasing value in the future? My experience leads me to believe that one is not justified in assuming that this treatment will ever influence any large proportion of the cases of sarcoma favorably.

Does the use of the toxins ever bring about a cure of sarcoma? It undoubtedly does have such an effect in a small number of cases. —J. C. Oliver, in the Ohio State Medical Journal.

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A cystitis which proves refractory to the ordinary treatment employed for vesical inflammations, should at once point to tuberculosis. And in this connection bear in mind that the vast majority of cases of tuberculosis cystitis are secondary to renal tuberculosis.—American Journal Dermatology.

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An overloaded bowel renders a stricture of fine calibre much more difficult of passage by causing congestion. Thus an impassable stricture may easily become passable with the complete evacuation of bowel contents.—American Journal Dermatology.

When flatulence and acidity prevent sleep, a dose of sodium bicarbonate and peppermint is much more efficacious than any sleeping draught.—Medical Fortnightly.

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Treatment of Profuse Sweating.—Dr. G. Norman Meachen, in the Practitioner for October, states that of the many remedies that have been recommended, those that are really useful are formaldehyde, potassium permanganate, salicylic acid, quinine, tannic acid and its derivatives, and boric acid. Broadly speaking, it may be said that powders are helpful for their drying and absorbing effects, while lotions are used for their astringent or antiseptic influence. He gives a selection of those formulæ which have proved their efficacy:

For sweating feet.—Bathe the feet well every night with a warm one per cent. solution of potassium permanganate; dry thoroughly. The next morning dust on the following powder:

℞ Potassium permanganate, ... ʒij;
Powdered alum, ... grs. xx;
Talcum powder, ... ℥j;
Precipitated zinc carbonate,
Zinc oxide, ... āā ℥ss.

Misce. Fiat pulvis.

If powders are objected to, white stockings that have been soaked in a saturated solution of boric acid may be worn. The strength of the permanganate bath may be gradually increased, and in mild cases this will bring about a cure.

When bromidrosis is a distressing feature, applications of formaldehyde are more suitable, though it must not be employed above ten per cent. strength, if there is any fissuring or secondary dermatitis present.

For sweating hands.—Bathe with one of the following lotions twice or thrice daily:

I.

℞ Tannic acid, ... ʒj;
Eau de cologne, ... ʒij;
Alcohol, ... ℥vi;
Water, ... ad ℥viii.

Misce. Fiat lotio.

II.

℞ Quinine sulphate, ... ʒj;
Alcohol, ... ℥vi;
Rosewater, ... ad ℥x.

Misce. Fiat lotio. —New York Medical Journal.

DR. CHAS. S. HUFFMAN,
CANDIDATE FOR THE REPUBLICAN NOMINATION FOR GOVERNOR OF KANSAS.

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ACUTE PANCREATITIS AND SUB-ACUTE PANCREATITIS.

DR. GEO. M. GRAY, Kansas City, Kansas.

Read before the Northeast Kansas Medical Society, Feb. 8, 1912.

In the work of Mayo, Robson and T. J. Cammidge, published in 1907, they give under the above head the symptoms, as follows:

Acute pancreatitis is usually ushered in by a sudden pain in the superior abdominal region, accompanied by faintness or collapse, and followed sooner or later by vomiting. There is usually some epigastric swelling with tenderness from the first, and if the warm, flat hand be placed over the epigastrium and retained there without movement for a time, it will be found that the swelling is diffuse, and not simply dependent on a distended stomach or colon, though later when pancreatitis is established the hollow viscera become inflated. It is almost constantly accompanied by constipation, so that it is quite usual for these cases to be mistaken at first for intestinal obstruction. The obstruction, however, is not absolute, flatus passes and a large enema may secure an evacuation; if the patient survives for several days, diarrhoea may supervene. The pain may be so severe as to produce syncope or collapse, and though the pain does not quite pass away, it has a tendency to be paroxysmal, and to be increased by movement; it is associated with well marked tenderness just above the umbilicus and between it and the ensiform cartilage. The pain is soon followed by distension in the superior abdominal region, which may become general and usually does so in the latter stages, by vomiting first of food, then of bile, and soon by black altered blood. The vomiting may be severe, and each attack of sickness aggravates the pain; rarely, vomiting may not be a prominent symptom; slight jaundice from associated catarrh

of the bile ducts and pressure is usually present, and deepens the longer the patient survives. The aspect is anxious, and the face is pinched, resembling the facies of peritonitis, which, in fact, is usually present; the pulse, which is rapid and small, is a better guide than the temperature, which may be normal, subnormal, irregular or high. In the ultra acute cases, the temperature is usually subnormal, but in the cases that survive for several days the temperature becomes irregular and may be excessive; delirium comes on in the latter stages. The distension and tenderness may prevent an exact examination of the pancreas, which would otherwise be found enlarged. Death usually supervenes from the second to the fifth day, from collapse, probably due to absorption of virulent matter, though in the less acute cases life may be prolonged and recovery may possibly occur. It is even possible for the trouble to resolve apparently completely, and then for a relapse to occur, this sequence being repeated on several occasions. Preceding description refers to acute pancreatitis generally, and applies to the hemorrhagic, gangrenous, or suppurative varieties, which are phases of the same infective condition, though the morbid appearances differ so much. In gangrenous pancreatitis the organ is dry and dark, or even black, and there can be little doubt, as Opie has remarked, that this condition represents a late stage of the haemorrhagic form. Concerning pancreatic haemorrhage neither clinicions nor pathologists are agreed on this subject, some believing that inflammation precedes the haemorrhage—among these being Fitz, who designates the disease haemorrhagic pancreatitis—others holding that the haemorrhage precedes inflammation, which is, in fact, caused by bacterial infection of the haemorrhagic effusion. It is probable that both views may be correct in different cases, for although a primary pancreatitis may be accompanied by haemorrhage, yet this origin is not the only one, and there are many cases in which haemorrhage precedes, and, in fact, is the cause of the inflammation; first, owing to the great tendency of the glands to disruption because of its soft structure when haemorrhage does occur; secondly, owing to the setting free of the pancreatic secretion which decomposes and digests the damaged tissues; thirdly, owing to the communication of the gland with the intestine, rendering the access of putrefactive organisms likely; and, fourthly, owing to the great tendency of the damaged gland and the effusion to become decomposed as soon as organisms gain access. These two varieties of haemorrhagic pancreatitis may at times be clinically differentiated; the ultra acute with a violent and sudden onset,

accompanied by collapse and ending fatally with extreme rapidity, being for the most part the ones where the heamorrhage precedes the inflammation, and the somewhat less, though still acute cases where the onset is more gradual, where the symptoms are not ushered in by collapse, and where resolution and relapse are liable to occur, being the ones where the inflammation precedes the haemorrhage. The varieties in which the inflammation precedes the haemorrhage may, in the severe form, approach the sub--acute variety of pancreatitis. These views simplify the subject and place the disease of haemorrhagic pancreatitis in a line with other well known inflammations.

DIFFERENTIAL DIAGNOSIS.

In an article in the December, 1909, number of the American Jcurnal of Medical Sciences, John B. Deaver reports six cases seen and operated upon by himself and diagnosed as acute pancreatitis; in summing up the differential diagnosis, he says that it is a matter of some difficulty in most cases; in a majority of instances, in which an incorrect diagnosis has been made, it has been that of acute intestinal obstruction; it is not difficult to see why this is so.

In both conditions, we have the sudden onset, the violent cramp-like pain, a slow pulse in the beginning; some distension, which gradually increases, and vomiting following the pain, with stoppage of gas and feces. The similarity is heightened by the fact that in pancreatitis the distension is largely colonic, and this often leads to a suspicion of an obstruction low down. At the onset of the disease, it may be impossible to differentiate the condition, yet the uncertainty should not last very long. In the first place, it is rare to find shock with occasional slow pulse and cyanosis in intestinal obstruction. Morever, it is, as a rule, localized to some point in the lower abdomen, rather than in the epigastrium, as in pancreatitis. As the case progresses for some hours, the distension becomes slightly plainer; the vomiting in obstruction is one of the cardinal symptoms. It is persistent, severe and becomes progressively worse. The vomitus becomes foul in a short time. In pancreatitis, the vomiting is billious in practically every instance; after a short time, it becomes less frequent. Far more distressing is the hiccoughing and belching associated with the pain. In pancreatitis, the distension is generally colonic, and not of high grade. In pancreatitis, the ileus may be absolute at first, yet often enemas result in passage of gas and true bowel movement. In acute obstruction, we can by the same means obtain only emptying of the large bowel and the passage of flatus; if it occurs at all, is very limited. In pancreatitis, slight jaundice

often develops; in obstruction, it is absent. Other conditions referred to as possibly simulating acute pancreatitis have been biliary colic, poisoning, impacted ureteral calculus. In these the course of events the other and distinctive signs, and in the former the history should soon serve to put us on the right track. Thrombosis of the mesenteric vessels, practically never diagnosticated except at operation or autopsy, may give us symptoms of ileus, very likely, it stimulates acute pancreatitis. Acute appendicitis has been the diagnosis of several cases of pancreatitis. It does not seem to me that these conditions are sufficiently similar to cause a mistake to be made often. Appendicitis is distinctly an inflammatory condition of the lower abdomen; its symptomatology is well marked and typical in most cases, and its signs, with a few exceptions, are not those of an upper abdominal lesion. Next to a diagnosis of acute obstruction in those cases of pancreatitis not recognized, there is that of an acute perforated peritonitis of the upper abdomen, be it of stomach, duodenum, or bile ducts. In the first two conditions, we can generally get a history which would be something of a guide to us. When the biliary system is the seat of the perforation, the history may be misleading, rather than a guide to us. In all these conditions, the sudden, agonizing pain in the epigastrium would at once point to a serious lesion of the upper abdomen.

TREATMENT.

The treatment of acute pancreatitis is one of the most important subjects which confronts the surgeon today. J. B. Deaver reports two recoveries in his six cases, which were drained, some by anterior incision which involved the traversing of the peritoneal cavity; and, second, a route through the left loin. While he classed these six cases as acute pancreatitis, yet none of them were of the severe type classed by Mayo, Robson, as ultra acute haemorrhagic pancreatitis, in which variety of the disease the prognosis must be extremely grave; but in spite of the gravity of the disease, it seems to me that drainage should be attempted if the case is not in condition of extreme collapse with cyanosis.

In conclusion, will report the following cases:

Mrs. Elizabeth Dreiling, age 56, married, housewife, residence, Victoria, Kansas; early history has had the ordinary diseases of childbirth; past history, mother of seven children; youngest ,10 years of age; has had stomach trouble, but no attacks of severe abdominal pain; is habitually constipated; present trouble: On November 9, 1906, was taken with very severe pain in upper part of abdomen, and vomited some throughout Friday and Sat-

urday, pain severe, but not cramp-like; no bowel movement; not even flatus. Sent for her physician first on Saturday, November 11th. He reports that he found her with normal temperature, says pulse was also normal, but was suffering extreme pain in the upper part of the abdomen; pain not paroxysmal; bowels had not moved for three days; vomited occasionally. He gave her a soap-suds enema, without results; patient some better on Monday, but no bowel movement. He saw her again on Tuesday, when he gave her a high glycerine enema, which was followed by the passage of some gas. Patient collapsed while he was passing the high colon tube, and he thought she was going to die at once. He says her abdomen was tender all over and rigidity was marked on this examination, temperature not taken, pulse rapid and weak. She entered St. Margaret's Hospital Wednesday morning, November 14; temperature normal, pulse 100; abdomen distended, tympanitic and tender all over. Bowels had not moved for five days; vomit if she would take any quantity of food or water into the stomach, vomitus bile stain, but not fecal. A palpable mass in upper right quadrant of abdomen; no peristaltic movement felt or heard. Urine, 1020, no albumen, no sugar, no pus, blood or casts. Blood examination: Whites, 10,000. Late Wednesday P. M., bowels moved in response to oxgall enema, but condition of patient is unchanged. November 15th, an exploratory laparotomy was done. Incision made over gall bladder, No stones were found, hepatic flecture of colon inflamed and dark in color. Some blood clots found in region of pancreas, small whitish areas of fat necrosis observed throughout the entire omentum and mesentary; patient died November 16; no autopsy was obtained.

Case 2.—Mrs. Lizzie Beach, age 48, married, housewife; admitted to St. Margaret's Hospital March 11, 1910; gave the following history: Had suffered for several years with indigestion, and for the past two years has had occasionnal attacks of pain in the epigastrium, which would last for a few hours; were not severe enough to call a physician; were not cramp-like in character, did not vomit with these slight attacks, and treated herself by rest in bed and application of hot plates to epigastrium. These attacks came perhaps as often as once a month. In November, 1909, she had an attack of jaundice, lasting about two weeks; no pain, or vomiting, saw her physician at his office twice during the attack.

Present Illness.—She was attacked with very severe pain in the epigastrium about 4 a. m., Wednesday morning, March

9th, 1910; vomited repeatedly. Her physician was called; he found her suffering intensely; pulse about 90, temperature he did not take; gave her a hypodermic injection of ¼ grain of morphine. He saw her six hours later; she was feeling better of her pain, but was still vomiting, and she complained that her bowels had not moved. No bowel movement in response to two enemas. She remained much the same until Thursday evening, when she seemed much worse, showing signs of shock, pulse about 110. Friday morning, early, she was removed to St. Margaret's Hospital, when she arrived in a state of profound shock; temperature¼ subnormal, pulse indistinct at the wrist, but about 161; extremeties cold and cyanotic; body covered with a profuse cold, clamy sweat. A hypodermoclysis was done at once; repeated again in six hours; she had rallied at this time and showed some improvement; continued improvement for 24 hours, during which time her bowels were thoroughly evacuated; but after 24 hours there was a renewal of the pain, accompanied by some elevation of temperature, temperature ranging from 100 to 103; pulse increasing in rapidity. When on the evening of the second day, she again developed extreme shock, accompanied by very rapid and weak pulse, cyanosis, gradually deepening until she died on the third day after admission to the hospital.

Blood counts made two or three different times showed whites about 10,000. An autopsy was done by Dr. Trimble, and the specimens I have here on exhibit for your inspection. They are fine specimens of acute-gangrenous pancreatitis, showing the candle-green spots, spoken of in Dienlofogs' work on practice, and considered pathognomonic of this disease.

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TREATMENT OF TYPHOID FEVER.

DR. C. F. CRONK, Anthony, Kansas.

Read before the Kansas Medical Society, May 4, 1911.

Typhoid has had much written about it; men of good practical worth, and much that is simply exploitations of some energetic, ambitious person whose writings were based entirely on fine spun theories, particularly since the etiology and pathology of the disease has become better understood. Prior to this period, while the disease was recognized, the treatment of it was a haphazard process, most of the attention being directed toward the pyrexia, as was the case in nearly all other diseases, the reduction of temperature being the aim of the physician, and being

familar with those drugs which accomplished this end, there was no trouble to reduce the temperature for a time only, for, as soon as these were discontinued, the temperature would return to annoy and worry the physician.

It is within the memory of almost everyone that the diagnosis of a case of typhoid fever meant weeks of anxiety to both physician and friends, with visions of crepe, and a long concourse of loving, mournful friends and relatives wending their way to the little country grave yard, to pay the last tribute to the departed loved one. The few who were able to withstand the depressing action of antipyretics, and the ravages of the disease after weeks, perhaps months of this continuous warfare against the physical forces by both disease and drugs, and finally emerged from the fire weakened in both body and mind, were looked upon as one returned from the dead, and even yet the diagnosis strikes terror to the heart of many, and well it might.

It is a disease that is known in almost every country on the globe, and it is not much of a respecter of persons. Those persons, however, between that period of early adult and middle life, being its favored victims. It is now impossible for a person to be sufficiently prepared to practice medicine, and not be familiar with the etiology and pathology of this disease, but this paper is to do entirely with the treatment and not with either of these important factors in this much dreaded disease. These fields have been ably and scientifically covered by the bacteriologist and pathologist, without whose able assistance, we would yet be groping in the dark in the practice of the noblest profession on earth.

To refer to the opening statement, since the establishment of the cause, and condition of this disease, attention has been directed mainly to the antiseptic treatment, a theory only. We know that bichloride, carbolic acid and kindred substances will kill bacteria, but it is only when they come in direct contact, and in sufficient strength. Is it reasonable to suppose that the tissues of the body can become sufficiently saturated with these poisons to kill germs, and not themselves suffer a like fate? Let us get away from the direct antiseptic theory of treatment of this disease, except as future investigation of our co-workers, the bacteriologist and pathologist, may develop a successful serum. Let us stop this over medication and dosage of our typhoid patients. Give them a chance to get well, remembering this once cardinal principle of disease, that their tendency is to recover.

I firmly believe that drugs and injudicious management of

many cases of typhoid fever, have written their sad story upon many a marble slab. I do not mean by this that ignorance or incompetency on the part of the attending physician, is responsible for these results. Many physicians allow the friends to influence their management of their cases, for fear of Dr. So and So being called in, or a possible dismissal from the case at the suggestion of some meddlesome outsider.

We must ever remember that typhoid fever means several days sickness, and instead of telling the patient and friends that you will be able to break it up in a few days, fortify yourself by stating facts, and once having satisfied yourself of the diagnosis, acknowledge your inability to break it up, but set about in an intelligent manner, the management of the case, and at the same time give your attention to the first step in the treatment. That is prophylaxis. Make inquiries and investigations as to the source of infection and remove it. Then impress upon the minds of all, the necessity of disinfecting all excreta, changing of bedding, clearing the room of all unnecessary articles of furniture, etc. All these precautions for the benefit of unaffected persons.

As to medicinal treatment. To me the treatment of typhoid is eliminative. Recognizing the pathological condition of a case of typhoid fever, will at once determine a rational treatment that is eliminative and there are three great channels through which this is to be accomplished; namely, bowel, skin and kidney.

Text books tell us that diarrhea is one of the symptoms of this disease. It is, but it is certainly a late one, and it is natures attempt at elimination through this channel, and any interference in this nature's effort to eliminate toxins, on the part of the physician, by giving opium or any other drug to lock up the bowel, simply because it is moving too frequently, is both unwise and injudicious, and unless there is some other reason very manifest, this drug has no place in the treatment of this disease. How many physicians make it a practice of checking the action of skin or kidneys in this disease. It is just as unnatural and unscientific to lock up the bowel, as to inhibit the action of either of these other two emunctories. In locking up the bowel the portal circulation is backed up, and the liver, the great gate keeper to the body in arresting poisons on their way from the intestines to the general circulation returning, some to the intestines in the bile, and either destroying or modifying others so as to convert toxines into antitoxines, is either handicapped or prevented entirely from performing this very important function in this particular disease, and when you do this, you simply destroy the protecting influence

of the liver, and divert all the toxines of this disease into the systemic circulation.

Now try it once, and see how quickly your patient will show symptoms of toxemia, after the bowel has been locked up for two or three days, and notice the delirium and approaching coma.

We have now arrived at the first important step in the medicinal treatment. Give those drugs which will keep the liver in as good working order as possible. I have done this by podophyllum. Sodium phosphate will accomplish the same results, but whatever is given, should be administered in small doses and daily. The former in one-twelfth to one quarter grain every four hours until three or four bowel movements are obtained, then discontinued until next day. This course of treatment will control any diarrhea of typhoid fever. A man who would try to assist a heavily loaded team over a hill, by hitching another to the rear end and pulling in the opposite direction, would be looked upon as being somewhat deficient mentally, and yet would be in the same class with physicians who would lock up the bowel in a case of typhoid fever, because it was moving too frequently. This may be putting it a little strong, but early experiences, and later observations extending over fifteen years, justifies this statement. Elimination is the only object to be obtained by drug or any other treatment, and as before stated, any effort directed toward antisepticizing the bowel, is not only time wasted, but in many instances injurious to the patient.

I shall not take up your valuable time by quoting authors and giving the different methods of treatment, but will mention a few drugs that have been exploited as intestinal antiseptics, only to dismiss them, as I think they have practically no place in the treatment of this disease, for the reason heretofore given, that is it impossible to render the bowel sterile by any means at our command. Bismuth, turpentine, salol, oil of cinnamon, calomel, eucalyptus, thymol, guiacol, sulpho-carbolate of zinc, acetozone napthalene, formaldehyde, etc. The only forces of which we have any knowledge, are the natural resisting forces of the body, and we have no evidence that they are increased by minute doses of germicidal substances, yet nearly everyone who treats typhoid will insist upon employing one or more of the above named substances, with, to my mind, very little, if any results, except to disturb the patient and to impress the friends that you are doing everything that can be done. There is one method, however, upon which the profession is very generally agreed, and that to my mind is of very great importance in the successful man-

agement of a case. I refer to the bathing, whether it be the Currie or Brand method, or sponging. Nothing, in my opinion, is of more importance than the daily sponging. This, athough questioned by some authors, is one of the great routes of elimination, and as I have said the treatment should be directed along this line. The fever is certainly toxic in nature, and the subsultus and delirium is not due so much to fever, as it is to toxemia, and any method that will eliminate these toxines will control the fever, delirium and other nervous phenomena. Therefore look well to the bowel, skin and kidneys, the three great channels of elimination. Doing this, you will have to give very little attention to any of these troublesome conditions.

I will now give the method that I have employed for the last fifteen years, and the results. Not having kept a tabulated report, I cannot give the exact figures except the number of patients I have lost.

As to mortality, rate statistics show conclusively that since the employment of baths, the death rate has been materially reduced approximately from 18.5% in John Hopkins hospital, to 9.1%. As to my own experience since following the eliminative method, covering a period of fifteen years, I have lost two patients. I have kept no accurate record of the number of patients treated, but I am quite sure that I have treated as many as the average physician, and even placing the number at 75, or an average of five each year, which is certainly very conservative, the mortality rate would be a little over 2½%, nor is this all. I have never had a case of hemorrhage or tympanites to any marked degree, not a single case of delirium, and but very little gastric disturbance, in fact the tongue and teeth remain remarkably clean. The patients are always in condition to enjoy the visit of the physician. These claims may seem to you to be extravagant, but they are absolute facts. I have often heard the diagnosis doubted by some physicians, and laity, because the patients were not sick enough, but I am satisfied with my ability to diagnose the disease occasionally, besides the number claimed as five patients a year, and that, in a section of the country where it is very prevalent, my statement is not extravagant. With but one single exception, and that in a very neurotic patient, in any of my cases, did I find my patients unwilling or unable to give me a welcome greeting, which adds very materially to the physician's feeling and satisfaction.

I have said, and I repeat, that many of the typhoid patients would do much better on fewer drugs. Of course if conditions

require heart tonics, they receive strychnine or digitalis or other tonics.

When first seeing a case showing symptoms of typhoid fever, I thoroughly empty the bowel with calomel, then follow up with good doses of quinine until the patient is thoroughly cinchonized for two or three days in order to eliminate possible malarial conditions. After this the temperature curve and characteristic pea soup stools, and other typhoid symptoms will be so prominent as to enable me to make positive my diagnosis. I then start in with daily small doses of podophyllum every four hours, with perhaps one-half drop of Fowler's solution, every hour or a drop every two hours. This is kept up throughout the entire course of the case, and constitutes practically the entire medicinal treatment. I have sometimes given teaspoonful doses of compound solution of chlorine in water every three or four hours, but I cannot say that I have seen any different results. The patient receives from two to several sponge baths during the twenty-four hours, and allowed plenty of cold water to drink, and if the temperature is very troublesome, a coil with ice water running through, placed over the abdomen for a few hours at a time.

This part of the treatment is very important, and is kept up daily regardless of temperature, as the bathing is not for the purpose of reducing the temperature, but for general effects. First, the excretion of toxines are increased; second, the conditions of the circulatory system is improved; the heart rate usually falls, the pulse becomes smaller, and harder, and dicrotism usually disappears and blood pressure rises; third, the mortality is reduced.

Indications for Bath.—Brand says that all cases of typhoid fever should be bathed from the start, and I believe this to be a good practice. The temperature alone should not be the indication for the bathing. The nervous symptoms are the most important. A temperature of 102.75 is not a matter of much consequence usually, while restlessness, delirium and other nervous symptoms indicate disturbance of nerve centers by toxines and a lack of elimination of these poisonous substances, which are usually dispelled by a gentle sponge bath. Diet is of much importance in the management of these cases. From the very nature of the lesion of typhoid fever, we should select a nutritious liquid diet, or at least one that will cause as little friction in passing over the ulcerations as possible. Milk, when it can be borne, is perhaps the best, and if there is any difficulty in curds forming, it can be largely overcome by peptonizing. Egg-whey, custards and other semi-solids can be given without any deleterious effects,

but the patient should be fed at regular intervals of three or four hours, and in quantities sufficient to cause no digestive disturbances. No prescribed quantity for each case can be established, but must be determined by the patients ability to take care of it. Much damage can be done, by over feeding as well as under feeding. Of course we must not forget the value of a good nurse, as nursing in this disease is of paramount importance, however, many of us are handicapped in general practice in the inability of many of our patients to afford this almost necessary adjunct to our management of these cases.

Complications of course arise in typhoid fever but in the course of treatments, I have followed, they have not given me any trouble. Perforation, of course, calls for surgical interference and in determining this course, age and condition of the patient determines our action. Ninety-five per cent of these cases die without operations, and favorable conditions may reduce this to to sixty or seventy-five, by surgical interference.

I shall not go further in the treatment of complications, but sum up by emphasizing, first, prophylaxis, elimination, nursing and diet.

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FISSURE IN ANO.

W. W. YATES, M. D., Topeka, Kansas.

Read before the Northeast Kansas Medical Society, February 8, 1912.

The anal canal is about an inch long and extends downward and backward, connecting the rectum with the surface of the body. The upper portion is lined with mucous membrane, the lower with skin, and a blending of the two occurs between. At rest the canal is a closed slit, the membrane being in contact and folded longitudinally. The distribution of the fibers of the sphincter muscles is of clinical importance. A few of the fibres of this muscle circle the anterior portion of the anus, but the larger portion of the muscle divides into equal parts and passes on either side of the anus. Very few fibres circle the posterior portion of the anus but the halves are here joined by connective tissue forming the posterior commissure. Many fissures are here located.

Anal fissures occurs oftener in women than in men, probably because constipation is more common in women than in men.

Fissures are of every degree and severity, from those causing slight pain on defecation to those which render defecation almost impossible by means of the excruciating pain. In severe fissure

there is always contraction of the external sphincter. This contraction increases the pain by pinching the sides of the fissure together and also prevents the movement of the bowels. In most fissures there is the loss of few drops of blood with each stool.

The ulcer is usually horizontal, one-half to two-thirds inch long, and apparently linear. However, when the anal folds are extended the ulcer assumes an ovoid or irregular shape. The edges are raised and frequently turned in. The base is red or gray and often bathed with pus. The depth does not often exceed one-third of an inch and the symptoms produced are out of proportion to the extent of the ulcer.

The site may be on any part of the canal but is oftener found at or near the posterior commissure than elsewhere. In women it is frequently located at the anterior commissure.

Pathology.—In chronic anal ulcer the edges are elevated and indurated, the base is hard, and the fissure may extend quite to or even into the muscle. The sphincter is usually hypertrophied and unyielding. In a recent ulcer may be found exposed nerve ends. These are not seen in older ulcers but perineuritis and intrafascicular neuritis develop and are the cause of throbbing pain during and long after exercise of the sphincter. This pain often radiates down the legs and to the back.

Etiology.—Constipation. Hard stools are by far the most frequent cause of fissure. In women childbirth is thought to cause anal fissure and the fact that the lesion is more frequently found at the anterior commissure in women than in men is due to the severe strain put upon the perineal body and sphincter muscles of the anus.

Syphillis and tuberculosis cause stricture as also does trauma as by injudicious use of the rectal tube. But most fissures are due to constipation.

Symptoms.—Small shallow cracks in the anal integument early cause burning pain during stool and for a few seconds after. There is every degree of discomfort and pain until the ulcer becomes intolerable and relief must be had. Spasm of the sphincter muscle is a constant symptom of severe anal ulcer. A little blood is usually passed, but the quantity is always small and there is seldom very much pus. A sentinal pile often accompanies the fissure and patient frequently complain of piles, not being aware of the true nature of the lesion. If constipation is not already present, it soon is developed by voluntary restraint of the bowels through fear of pain.

Pain is always present but varies with the location and charac-

ter of the ulcer. The ulcer which extends down into the skin is more acutely painful than that higher up. Pain coming some time after stool, throbbing like tooth ache, is apt to be due to an old ulcer high up in the anus and only visible by the aid of the speculum. In women fissure in ano often produces bearing-down pains in the uterus and many women have had useless local treatments when careful examination would have revealed the real trouble. Retention of urine and painful urination, pain in the back and legs and neuralgia are other reflex symptoms.

There is a waste of nervous energy that sooner or later undermines the patient's health. Tuttle says that facial and occipital neuralgia, spinal irritation and temporary strabismus have been known to disappear almost immediately after operation for fissure, and were apparently cured by the operation.

Diagnosis.—Pain at or after stool is always the most prominent symptom. Local examination will determine the cause of the pain. If the sentinal pile appears, pressure on this causes pain. If an induration is felt pain will be caused by palpation. Ulcers low in the canal can be brought into view by partially everting the anus. Higher ulcers if indurated, may be felt by the examining finger or brought into view by the fenestrated speculum. Contraction of the sphincter is always caused by irritation of the ulcer.

Treatment.—Non-operative. If possible, regular action of the bowels should be secured. Rectal injection of olive oil is a valuable measure, or of olive oil and glycerine. Sodium sulphate or phenylphthalein are useful in some cases.

Where the ulcer is not indurated and the sphincter is not hypertrophied, silver nitrate or one of the newer silver preparations may cure the ulcer. Ichthyol is also a useful remedy. Recent superficial ulcers can usually be cured by regulation of the bowels and the use of some dusting powder. A deep ulcer with raised edges and indurated base, where the sphincter muscles are hypertrophied, is seldom cured without operation.

Incision.—Boyer taught that fissure was due to spasm of the sphincter and cured by cutting through the muscle. Later it was learned that the incision need not pass entirely through the sphincter, and that it was better to cut through the fissure than to make a new lesion except in cases where the ulcer was located in the anterior or posterior commissure. The incision must cross the muscle's fibres to relax the sphincter. When the fissure occurs at the anterior or posterior commissure the incision made through the ulcer will separate and not cross the fibres, and therefore the incision should be made some distance on either side of the lesion.

A fissure occurring in the side of the anus may be cured by cutting a little more than its length and one-third of an inch below its depth into the muscle. This relieves the spasm of the sphincter and allows the ulcer to heal. The incision should be carried some distance below the lower edge of the fissure in order that no pocket can be formed in which feces may lodge.

The most common operative treatment prescribed is dilitation and for fissures not situated at the commissure and not too much indurated this measure suffices to cure. It requires deep anesthesia whereas incision may be done under cocaine.

The sphincter is gradually stretched for four to six minutes until it offers little resistance to the thumbs. The anus is examined, piles removed if present, and the fissure carefully inspected. Before the sphincter regains its full contractural power the ulcer heals. The operative procedure selected depends upon the state and location of the ulcer. Sentinal piles, when present, should be removed and the upper canal explored for polypi or ulcers.

When the ulcer is very old, and perineuritis is present, excision of the fissure and incision of the sphincter muscle offers better prognosis. Excision is often to be preferred in very old people and in the emaciated. Palliative treatment of fissures in ano only provokes the situation by increasing the constipation.

SUMMARY.

1. Fissure in ano is very frequently overlooked.
2. It is capable of undermining the health.
3. Through reflex symptoms a diagnosis is frequently made of stricture of the urethra, uterine trouble, or some other more or less remote disease.
4. The condition of the rectum and anus should be ascertained by questions, and by local examination when symptoms point to possible trouble in that region.
5. Dilitation by force, and incision, each in its own selected cases, offers almost certain cure in this painful and frequently intolerable malady.

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HYPERCHLORHYDRIA—DIAGNOSIS AND TREATMENT.

WM. C. LATHROP, M. D., Norton, Kansas.

Read before the Kansas Medical Society, May 4, 1912.

I often wonder if the city practitioner is as careless in attempting an accurate diagnosis of gastric diseases as we physi-

cians practicing in the rural districts. It was much easier for me to make a diagnosis of hyperacidity a few years ago before I began systematically giving test meals, than it is today. In fact during the first months of gastric work, I made a diagnosis alone, on the degree of acidity found; yet at times I observed many of the patients apparently having the most distress, had perhaps a normal or but slightly increased acidity. This leads me to think that perhaps an over-sensitive mucos membrane to HCL might exist, or we might term it an idiosyncrasy on the part of the stomach to HCL.

It is quite generally conceded that the amount of free HCL varies somewhat between 0.1 and 0.2 per cent. Therefore when we find the free HCL over this, we may consider it is hyperacid.

My personal observation, while it has no particular value, leads me to believe that there is no fixed line of demarcation chemically, where the symptoms of hyperchlorhydria become manifest. Each stomach is a law unto itself as regards the secretion of HCL and is subject to as many variations as is the human pulse. At times, to my surprise, I have found persons carrying an acidity of 80 to 90 T., with comparatively little discomfort; while in other cases patients with perhaps an acidity of 60 T., gave marked clinical symptoms of hyperchlorhydria.

Talma (1), claims that the symptoms of hyperchlorhydria are due to a hyperesthesia of the mucus membrane of the stomach to HCL, and this definition seems to me to more satisfactorily answer our purpose than one merely taking a definite per cent as its basis. There is a little discrepancy whether we should consider hyperchlorhydria an increase of the total acidity, or whether it be limited to an increase in the free HCL as really the name indicates.

Ewald, Rosenheim and Boas (2), maintain that hyperchlorhydria applies to an increase of the total acidity of over 60 T., while Reigel says there must be a marked increase of the free HCL to over 50 or 60 T. I have noticed in the cases coming under my own observation, which gave marked symptoms of hyperacidity, that the majority showed a free HCL of 70 T., with perhaps a total acidity of 100 or more.

I wish to confine my remarks, on hyperchlorhydria from the standpoint of a true gastric neurosis, and not as a reflex entity.

The typical patient of hyperchlorhydria is well illustrated in the gastric complaints commonly found in a class of people in which worry and mental excitement are prevalent, such as those commonly found bartering on the Board of Trade; when stocks

are high and advancing, all is well; but let them drop below his margins, and immediately his stomach begins to disturb him. He has pains and aches of every kind varying from fullness in the epigastrium, pressure, acid eructations, unsatisfied hunger to intense spasmodic pains. These disturbances do not come on until the albumen radical of his meal has been satisfied, which is usually from one to three hours after eating, depending on the amount of albuminous foods taken. It is after the albumins are satisfied and an excess of free HCL is in the stomach that his trouble begins; in other words: is it the free HCL that causes his discomfort? His nutrition is good, he is well nourished, he has an over-digestion rather than an indigestion. His stomach is frequently emptied in three hours instead of five, except in those cases in which pylorospasm is a frequent accompaniment.

Constipation is almost invariably an accompaniment of hyperchlorhydria. Examinations of the stomach contents reveals the albumins well digested, but the starchy foods undigested. This is due to the fact that under normal circumstances the ptyalin ferment acts in its digestive capacity on the starches until the alkalinity of the saliva and gastric juices has been more than neutralized by the HCL of the stomach. Thus, instead of allowing the ptyalin its usual time in the digestion of starchy foods, the early appearance of the free HCL cuts short its working period from one-half to one-third its normal time. Physical examination of the abdomen reveals a slight yet diffuse tenderness over the epigastrium but the localized tender points on deep pressure such as are found in cases of gastric or duodenal ulcer, gall bladder diseases, and appendicitis, are wanting.

The diagnosis of this symptom-complex as a neurosis consists not only in the finding of the above symptoms and conditions, but in eliminating all other abdominal diseases with which we so commonly find associated the irregular types of hyperacidity. I mean by this the hyperacidity found in gall-bladder disease, or appendicitis occurs at irregular intervals. For instance, it is quite common that the hyperacidity from gall-bladder disease selects the early morning hour when the patient first awakens for, its manifestations; it is noticable that the ingestion of albuminous foods does not relieve this type of hyperacidity as it does invariably the type with which this paper deals.

The hyperacidity so commonly associated with gastric ulcer, is characterized with great pain when food is taken, not as the result of the hyperacidity, but from the ulcer. Here also is found the localized tender points on pressure. Nutrition is below par;

blood in the gastric contents or in the stool is found at recurring intervals. Therefore in order to be effective in the treatment of this disease, we must satisfy ourselves as to whether it is a reflex condition or whether any discernable cause can be found.

As the treatment of this condition is so elaborate and varied, I will only suggest as to its selection, and as this disease is more frequent in that class of patients in which mental strain and mental overwork is common, we must use every endeavor to adjust as far as possible, these mental environments. This perhaps may be more theoretical with us than practical with the patient, because frequently he is unable to meet our demands in this respect, as it would many times mean a change in his occupation.

Errors in the selection of our foods and drink, highly seasoned foods, extreme hot and cold drinks, stronger alcoholics as whiskey and wines, improper and hurried mastication, lead very promptly to the establishment of a hyperchlorhydria; hence their avoidance is necessary in its successful treatment.

In a limited manner, I will discuss the treatment from a dietetic standpoint. There are two recognized methods of treatment; one in which the patient is given a diet rich in albuminous foods which completely keep saturated the hydrochloric acid radical, which relieves him, but which, in my judgment, has no tendency towards curing his condition. The second method in which the quantity of albuminous foods is materially lessened, which in turn requires lessened HCL for their digestion, and substituting a diet rich in fats, carbo-hydrates, and a limited amount of proteids.

It is a moderately well accepted fact that fats lessen the secretion of HCL. If this be true the change from the richly albuminous diet to the one rich in hydro-carbone, is the first requisite. We may allow ad libitum, butter, cream, cocoa and fat meats. Frequently I have found the administering of from 100 to 500 cc of olive oil before breakfast, most beneficial. This not only serves the purpose of reducing the secretory function, but also aids in the relief of the constipation which is so frequent in this disorder.

Water should be restricted with the meals, but allowed freely three to four hours following the meal. Soon the patient discovers drinking large quantities of water gives him much relief; perhaps not realizing the method in which it acts by diluting the hydrochloric acid in his stomach. The taking of a glass of milk two or three hours after meals or at the times the symptoms of hyperacidity appear, will in like manner relieve our patient.

Numerous writers are in favor of allowing five small meals per day, thus keeping the hydrochloric acid more nearly saturated, instead of the three heavy meals ordinarily taken. As to the value of drugs for the relief of this condition, my experience has been limited, yet moderately successful. Vaughn suggests the use of nerve sedatives, bromides, valerinates for the relief of the primary neurosis. Nitrate of silver, either in pill form, ⅛ to ¼ grain, or in a 1 per cent solution, of which drachm doses well diluted with water, given just before the meal is very effective. Cases in which pain is a prominent factor, extract of belladonna 1-8 to 1-6 grain will aid considerably in the relief of the pain. Alkalies and anti-acids, such as bicarbonate of soda, bismuth-subnitrate, magnesium sulphate aids materially in the immediate relief of the hyperacidity. I have used nitric acid, 1 or 2 mms., well diluted with water, with seeming benefit. Even it is said that the beneficial effect of bismuth-subnitrate is due to the fact that nitric acid is liberated in the stomach.

Turck (3), lauds very highly the hypodermic injections of atropine sulphate beginning with 1-100 gr., and increasing to 1-60 gr. as rapidly as possible, giving one injection each day; following this treatment, he likewise uses physostigmine, beginning with about 1-60 gr. and increasing to toleration, with which method he claims most excellent results.

It has been my custom about two or three hours after meals to administer magnesium carbonate in sufficient doses to relieve the on-coming acidity, as well as the accompanying constipation.

In something like twenty cases, I have used gastric lavage, first with normal salt solution, then instilling one-half pint of silver nitrate solution, 1-1000 for about 30 seconds, then withdrawing same and neutralizing any remaining excess with more normal salt solution. Whether the effect has been purely psychical or not I can not say, but the results have been most satisfactory, when used in conjunction with other systemic treatment.

1.—Zeitschrift f. klin. Med., 1884, Bd. XIII.

2.—Strauss, Diseases of the Digestive System, 1906.

3.—Med. Rec. Feb. 12, 1910.

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Cysts of the corpus luteum usually remain small in size and so very little general attention has been paid to them. They are of quite frequent occurrence and many times give rise to marked pain. When found they should be removed and the wound in the ovary closed with fine catgut. Many times this condition has been mistaken for appendicitis.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS: J. E. SAWTELL, CHAS. S. HUFFMAN, O. P. DAVIS.

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EDITORIAL

Give me the storm and tempest of thought and action, rather than the dead calm of ignorance and faith. Banish me from Eden when you will; but first let me eat of the fruit of the tree of knowledge.—Ingersoll.

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Any member of the society failing to receive the Journal, should notify the editor at once. A copy for each member is printed every issue and if you do not receive yours, you will confer a favor upon the editor by promptly reporting the error.

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Joseph Baron Lister, the father of antiseptic surgery, died at his home in London, England, February 11, at the age of 84. He was best known as the originator of antiseptic surgery, although his achievements in other scientific pursuits would have made his name immortal. His life has been a useful one, and his accomplishments will, as they have in the past, be a stimulus for all.

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The Shawnee County Medical Society has adopted some features which promise to be of a great deal of benefit, and one which other county societies could adopt to advantage. Anything that will help to keep up the scientific interest of society meetings

should be looked upon with favor, and Shawnee county has certainly taken the lead for originality Their attendance has improved since adopting this plan.

1. Meeting every Monday evening.

2. Membership divided into four sections with a leader for each. Each section will conduct the program for one meeting of each month. The object of this is to make a little rivalry between the sections and in that way improve the character of the program.

3. One meeting during the year to be held at each of the hospitals. Programs to be of a clinical nature.

4. A rating and collection bureau. The latter is being carefully worked up, but is not yet in operation.

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The time is fast approaching for our annual meeting at Hutchinson, and in all probability it will be the banner one in the history of the society. We owe it to ourselves and our patients to attend, getting a two-fold benefit in return for the little effort required to make the trip. In the first place the rest and relaxation are as great tonics to the tired and jaded mind, and the meeting of old friends, and the entertainment by the Reno County physicians will be appreciated and remembered by us all for years to come. Secondly, the scientific program and discussion, will be a great help to solve perplexing questions, and light up new roads. And lastly, we owe it to our society to do our share toward keeping it upon a sound basis where it will do the greatest amount of good for the greatest number.

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Let not an opporunity pass by without doing something that will help Dr. Huffman's candidacy for Governor. If the opportunities do not present themselves, make them. He is making an active canvass and your active support will help largely to secure his election. See your neighbors and urge them to support our candidate. Show them his platform, which appears in this issue and explain his qualifications, which are many. Now is the time to put a man in the executive chair who can fitly perform all of its duties with justice to all. He needs your help. *GET BUSY!*

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Dr. Chas. S. Huffman was born at Vincennes, Ind., and attended the common and graded schools in his home state. He came to Kansas in 1883. He is a graduate of the Medical Department of the University of Missouri, and has practiced his profes-

sion at Columbus, Kansas, since graduation, except the time that he was away in the army. He was assistant surgeon of the 20th Kansas, U. S. V., and went with that regiment to the Phillipines, and served in the various campaigns during the Filipino Insurrection. He was mustered out with the regiment on his return home. He was elected secretary of the Kansas Medical Society in 1903, and has served in that capacity since, during which time the society has been re-organized, and we now have a compact and solid organization in this state.

He was elected to the state senate in 1904, and re-elected in 1908. In the senate he had charge of the Pure Food Bill, and was active in getting that enacted into a law, and many other measures pertaining to Public Health and the general welfare of the state. At the last session of the legislature he was active in the support of the Vital Statistics Measure, which was made a law at that time. In the last two sessions he has been Chairman of the Ways and Means Committee, the most important of any committee assignments, and has had much to do with the public expenditures of the state.

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THE HUFFMAN PLATFORM.

In becoming a candidate for the nomination of Governor on the Republican ticket, the only claims I have to present, are, that I have been a citizen of Kansas for thirty years, and have always taken an active interest in the welfare of my home town, county and state. Having served for eight years in the state legislature, as a member of the senate, I helped to pass many of the laws now on the statute books. I expect to stand squarely on my record while serving in that body. I may have made mistakes, but sincerely thought I was working for the best interests of the state.

I do not see the need of much new legislation at this time. Our present statutes are cumbersome, and top heavy with enactments that are obsolete, and many of them difficult to enforce. There are laws that should be amended, strengthened and made more plain, also a better interpretation and enforcement of the laws we now have.

I think that the time of the Chief Executive of the state, could not be better employed than in meeting the people over the state, and co-operating with them in pushing the cause of good roads.

The last legislature was liberal in helping the country schools. This liberality should continue, considering the vast army of young people, who are not inclined, or cannot enter the high schools, or colleges, and every means should be given them, that they

may develop into the best possible citizens. This can be done without detracting in the least, from the higher institutions of learning.

I am in favor of a plan being worked out consolidating the Boards of Regents of our state educational institutions into one board. In the matter of economy, this would be a great saving to the state. without impairing the efficiency of the splendid institutions we now have. The one board of control for our charitable institutions, has worked to the advantage of the state, and the same would be true with one board for our educational institutions.

I think the state should deal fairly with all; whether they be great corporations, farmers, small tradesmen or laborers, and the state should command and demand respect for, and compliance with all laws enacted for their control and protection.

Labor should be protected, and the laws enacted for the protection of life and health enforced, and every possible thing done to better the condition of the man who labors on the farm, in the shop, on the railroad or in the mine.

I am in favor of the impartial enforcement of all laws, and shall stand for everything that will advance the moral well-being of the state, and keep up her high standard of citizenship.

In asking the support of the Republicans at the primary election, in 1912, I wish to say that I am not a candidate of any faction, but simply asking the nomination at the hands of the Republican voters of the state.

I have always voted and worked for the principles embodied in the Republican platforms adopted in the past.

I shall make no promises except to the public.

If nominated and elected, the state of Kansas shall have my best efforts during the period of my service.

Columbus, February 20, 1912. CHAS. S. HUFFMAN.

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Dr. C. S. Huffman, as the writer knows him, is a close observer, a deep thinker, a brief talker, a broad minded, level headed man, genial and pleasant in his personality; positive in his convictions, yet liberal enough and big enough to be convinced by experience or sound and reasonable argument when mistaken. He has shown exceptional ability as an organizer, both in business and in medicine, and possesses unlimited capacity for hard, unostentatious work.

That he is a success in the practice of medicine is abundantly proven by the fact that even now, three years after retirement

from active practice, his former patients still seek his service. The State Medical Society has elected and re-elected him its secretary, the most important office in the gift of the society, and he is still a guiding spirit in the State Board of Health, which, as far as the welfare of the people is concerned is, of all the State Boards, the most important.

Although a member of the regular profession, both in a private and an official capacity, he is neither narrow nor dogmatic in his views toward other sects, and he is broad enough to recognize and appreciate the good in all of them. And as a state senator, while active in support of public health laws he has opposed all laws that would unfairly hamper or oppress other recognized medical sects than his own.

In addition to his high professional attainments, Dr. Huffman is a good business man—a combination that rarely obtains in the medical profession. At the present time he is the President of the Columbus State Bank, and he would not be successfully filling that position of trust and honor did he not possess executive and business ability to an exceptional degree.

He did not enter business life however, until he returned from the Phillipines, where he served his country to the end of the war. The honors he had earned soon arrived. He was elected to the state senate and soon after to the highest post of honor in the medical corps of the Kansas National Guards that his comrades could give him.

At the expiration of his first term he was relected to the senate by an overwhelming majority. As chairman of the Ways and Means committee he came to know the affairs of the state, not through hearsay, partisan newspapers or prejudiced reporters, but through hard, persistent, personal work in his official capacity. No man in Kansas is better informed regarding taxation, state appropriations, and expenditures of the health needs of the people of the state than Dr. Huffman. In the senate he was one of the few real leaders, not only because of his influential position and executive ability, but because of his remarkable tact and diplomacy in smoothing out factional differences. He showed his ability in this regard before, when, as Chairman of his County Central Committee, he brought Cherokee back into the Republican column after ten years of populism.

While in the senate he was influential in passing the public utilities, the anti-pass, the vital statistics and the pure food laws all of which are invaluable to the people of the state.

His platform declares for fewer and simpler statutes, for a

unification of the various boards of regents to the end of lessening expense and increasing efficiency. He believes in better roads and better schools, in prevention of disease and the protection of the health and lives of all citizens regardless of their station, class or color.

His record as a man, as a physician, as a soldier, as a state executive is absolutely clean and unselfish. His record in his home town has gained the support of democrats and republicans alike; his service as secretary has earned the solid support of the whole medical profession; his conscientious service in the senate deserves the support of the whole people.

As commander in the Kansas National Guards, as secretary of the state society, and as chairman of the Ways and Means committee he has acquired a knowledge of the state politically that will be invaluable to him as our chief executive, and no man now before the people, and under conditions as they now exist is so well qualified for the governorship as Dr. Huffman.

Our state has had excellent business governors and shrewd lawyer governors, but never a governor so eminently capable of safe-guarding the welfare of the whole people or of administering the personal as well as the financial interests of the individual.

J. E. S.

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RESOLUTIONS.

At the meeting last week of the Saline County Medical Society, which meeting was well attended, the following resolutions was unanimously adopted:

Resolved, That the Saline County Medical Society in regular meeting assembled, endorse the candidacy of Senator Chas. S. Huffman for nomination for Governor, and that we pledge him our hearty support, both collectively and individually, in the coming primary.

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At the meeting of the Wyandotte County Medical Society held January 30th., the following resolution was introduced by Hon. J. K. Cubbison, and unanimously adopted:

Resolved, That we heartily endorse the candidacy of Senator Chas. S. Huffman for Governor, and pledge him our best efforts to secure his election. There were 80 physicians in attendance and the resolutions was carried with great enthusiasm.

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At a meeting held January 29th., in Topeka, the Shawnee

County Medical Society unanimously adopted a resolution endorsing Charles S. Huffman for Governor.

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Resolutions adopted by the Allen County Medical Society:

Recognizing in our friend and co-worker, Dr. Chas. S. Huffman, the highest type of statesmanship, his splendid efficiency as secretary of the state medical society, ability as a physician and high standing as a man:

We, the Allen County Medical Society in regular monthly meeting assembled, do most heartily endorse his candidacy and in every way pledge ourselves to aid in his nomination and election to the exalted office of Governor of the State of Kansas.

Iola, Kansas, February 27, 1912. P. S. MITCHELL, M. D.
F. W. NORTON, M. D.
O. L. COX, M. D., Committee.

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Resolutions adopted at the joint meeting of the medical societies of the Ninth and Tenth Councillor Districts(comprising 14 counties in Northwestern Kansas), held at Norton, Kansas, February 20, 1912:

Whereas, At the earnest solicitation of his friends, Senator Chas. S. Huffman, of Columbus, Kansas, has consented to become a candidate for Governor, therefore, be it

Resolved, By the Tri-County, the Western Kansas, the Decatur-Norton, and Phillips County Medical Societies, in consideration of his most excellent services to the people of Kansas for the past eight years in the State Senate, and believing in his peculiar fitness for this office, most heartily and unreservedly endorse his candidacy. Be it further

Resolved, That these resolutions be spread on the minutes of these societies and that a copy be sent to Senator Huffman, and that they be published in the Journal of the State Medical Society.

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The following resolutions presented by Dr. Geo. M. Gray and seconded by Dr. C. C. Goddard, were unanimously adopted by the Northeast Kansas Medical Society, at the annual meeting, held at Lawrence, February 8, 1912.:

Resolved, By the members of the Northeast Kansas Medical Society, that they, without regard of party affiliation, endorse the candidacy of Dr. Chas. S. Huffman, of Columbus, for Governor of Kansas, and pledge him their individual support.

SOCIETY NOTES.

Following is the program of the Harvey County Medical Society for March:

"THE GALL-BLADDER."

"Etiology, Pathology and Diagnosis of Diseases of the Gall-Bladder, Dr. J. L. Grove. Discussion, Dr. D. G. Buley.

"Indications for and Technique of Gall-Bladder Operations," Dr. R. S. Haury. Discussion, Dr. J. T. Axtell.

Differential Diagnosis, Diseases of the Gall-Bladder, Dr. Max Miller. Discussion, Dr. L. T. Smith.

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The medical Society of the Missouri Valley will hold their twenty-fourth semi-annual meeting at Colfax, Iowa., March 21-22, 1912, under the presidency of Dr. J. M. Bell of St. Joseph, Mo.

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The following program was given by the Wyandotte County Medical Society, February 13th:

Meningitis Symposium; Etiology and Pathology, Dr. C. C. Nesselrode.

Symptoms, Diagnosis, Treatment and Prophylaxis, Dr. Farquahard Campbell.

The following were elected to membership: Albert Harmes and T. D. Bourke.

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Franklin County Medical Society, January 31, elected Dr. John B. Davis, president and Dr. Willis L. Jacobus, secretary, both of Ottawa.

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At the January meeting of the Cloud county medical Society, held in Concordia, the following officers were elected for the ensuing year:

Dr. F. A. McDonald, President, Concordia; Dr. Chas. Stein, vice-president, Glasco; Dr. E. N. Robertson, secretary, Concordia; Dr. W. F. Sawhill, treasurer, Concordia; Dr. S. C. Pigman, delegate to state medical society, Concordia.

At the regular meeting, held in Concordia, Februray 20, the following program was given:

"Treatment of Pneumonia", Dr. S. C. Pigman, Concordia.

Experience in the Use of Some of the Newer Therapeutic Agents,; Salvarsan, the Serums, etc., Dr. A. Jeaver, Concordia.

The attendance was good and the papers were enjoyed and discussed by all present.

E. N. ROBERTSON, Sec'y.

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The meeting of the Ninth and Tenth councillors districts at Norton, held February 20th, was undoubtedly one of the largest and most enthusiastic gatherings of medical men ever held in the western portion of the state.

An unusually interesting and carefully prepared program was rendered, many of the subjects illustrated by drawings, X-Ray and stereoscopic illustrations.

An elegant banquet was tendered the visiting physicians by the business men of Norton who are justly proud of the fact that their city boasts of the most progressive and wide awake physicians of the west.

The societies represented, passed resolutions (published in another collum), relative to the candidacy of Senator Huffman for Governor.

The next meeting of the Society will be held at Goodland, in June. The following program was rendered:

PROGRAM.

"Chorea", C. C. Funk. Discussion, Dr. Shewmaker.

"Care of Woman During Puerperium", H. H. Johnson. Discussion, C. W. Ward.

"Medical Dogma and Orthodoxy," F. A. Carmichael, Discussion General.

"Tonsil—with mention of kinds and diseases of, Medical and Surgical Treatment," C. W. Cole. Discussion, Dr. Gulick.

"Injuries at the Elbow," Illustrated; W. C. Lathrop. Discussion, R. W. Dillingham.

Councilor's Report.—E. J. Beckner, C. S. Kenney.

Address, C. S. Huffman, Secretary of Kansas State Medical Society.

MISCELLANEOUS.

Business meeting, Case reports.

Reception, 5:00 p. m., Banquet, 6:00 p. m.—Bower's Tavern.

Auditorium, 8:00 P. M.,—"Pittsburg Survey." Illustrated Lecture 'The Sanitary, Moral, Social and Political Situations in Pittsburg, Pennsylvania, S. J. Crumbine, Secretary of the State Board of Health.—

F. A. CARMICHAEL, Secretary.

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The Northeast Kansas medical society met in regular session

in the City Hall, Lawrence,and was called to order at 2 p. m., by President M. T. Sudler.

Minutes of last meeting read and approved. The secretary reported that Wyandotte County Society was the only one to send in dues to the society, as a county, for the year 1912. After some discussion, relative to the collection of dues, the following motion was carried:

That, The secretary-treasurer be instructed to institute a campaign to bring all the counties comprising this organization, into the society as a whole, and if any county does not elect so to do, to receive membership from individual members of such county society.

The following nominating committee was then appointed by the president: Dr. Noah Hays, Seneca, Nemeha County, chairman; Dr. P. B. Matz, Leavenworth County; Dr. W. L. Lindsay, Shawnee County; Dr. J. E. Sawtell, Wyandotte County; Dr. Leon Matassarin, Douglas County.

After deliberation the nominating committee recommended the following members as officers for the coming year:

President, Hugh Wilkinson, M. D; vice-president, L. V. Sams, M. D; secretary-treasurer, C. C. Goddard, M. D.

Upon motion the rules were suspended and the report of the nominating committee was adopted.

At this time Dr. W. L Lindsay and Dr. S. A .Johnson in behalf of the Shawnee County Medical Society invited this Society to hold its next (October 10, 1912), meeting in Topeka.

The invitations of both were unanimously accepted.

Dr. N. Hayes of Seneca then presented a paper on "Blood Poison" which was received and discussed by Drs. Barney, Gray, Lindsay, Liston, Smith, Goddard, Sutton and Davis.

Acute Hemorrhagic Pancreatitis, was the subject of a paper by Dr. Geo. M. Gray, Kansas City, Kansas, which was received and opened for discussion. Questions were asked by Drs. Wilkinson and Skoog which were answered by Dr. Gray.

Dr. C. C. Goddard of Leavenworth, Kansas, then read a lengthy paper on the subject of "Effects of Some Mental Diseases on the Public.", which was accepted and opened for discussion; Drs. Sutton, Davis, Blair, Lindsay, and Skoog and closed by Dr. Goddard.

The following resolutions was presented by Dr. Geo. M. Gray of Kansas City, Kansas, who moved its adoption:

Resolved, By the members of the Northeast Medical Society that they, without regard to party affiliation, endorse the candi-

dacy of Dr. C. S. Huffman, of Columbus, Kansas, for Governor of Kansas, and pledge him their individual support. Motion was seconded by Drs. Goddard and Noah Hayes, and was carried.

Dr. H. Milton Connor then presented an interesting paper on "The Value of Laboratory Diagnosis", which was read and discussed by Drs. Blair and others.

Moved and seconded that the discussion of the remaining papers be eliminated on account of the lack of time—carried.

A paper entitled "Dietetic Treatment of Chronic Nephritis" by Dr. P. B. Matz of Leavenworth County was then read received and on motion was referred to the committee on publication .

Dr. W. M. Mills of Topeka then read a paper entitled "A Recent Hematoma of Ovary, Simulating Ectopic Pregnancy", which was received by the society. Dr. A. L. Skoog of Kansas City gave a talk on "Some Practical Points from Cerebro-Spinal Fluid Studies", which was, on motion, accepted by the society.

The subject "Fissure in Ano" was then presented in a paper by Dr. W. W. Yates of Topeka, which on motion, was accepted by the society.

The meeting then adjourned to the Eldridge Hotel, where a banquet was given to the members of the society by the Douglas County Medical Society.

Meeting was called to order at 8:30 p. m., by Dr. E. J. Blair, vice president.-

Mr. J. B. Wilson of Lawrence was then called upon to present a paper entitled "Some Legal Rights and Obligations of the Physician and Surgeon", which was received by the society, and on motion, was opened for discussion. Dr. W. E. McVey of Topeka opened the discussion, Drs. Yates, Davis followed. J. B. Wilson closed discussion.

Moved and seconded that Judge Wilson be thanked by the society for his paper—carried.

Dr. W. L. Sutton of Kansas City presented a paper entitled "Anesthesia by Rectal and by Tracheal Insufflations of Ether," with demonstration by apparatus, which was received by the society and discussed by Dr. M. T. Sudler.

Clinical Experience with Anti-Typhoid Vaccine was the subject of a talk by Dr. Harris Boughton of Lawrence, which was received by the society.

Thanks of the society were voted to Douglas County Medical Society for their entertainment. Meeting adjourned to meet in Topeka, October 10, 1912.

MERVIN T. SUDLER, President.
L. V. SAMS, Secy-Treas.

NEWS NOTES

Dr. S. J. Crumbine, dean of the medical department of the Kansas University and secretary of the state board of health, attended the meeting of the Eighth Annual Conference of the American Medical Association. on Medical Education, Medical Legislation and Public Health, held in Chicago, February 26 and 27.

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The state board of health of Kansas has made arrangements to supply diphtheria anti-toxine free to every patient unable to pay, upon requisition from a physician.

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REVIEWS.

Cancer of the Breast.—W. S. Thorne, San Francisco (Journa A. M. A., February 17), emphasizes the fact that in a certain percentage of cases of tumors of the breast diagnosed as malignant do not undergo malignant degeneration and that the histologic arrangement of a tumor does not always necessarily determine its future life history or development. He quotes Dr. M. G. Wells (Journal A. M. A., May 29, 1909, p. 1731),as to the natural defense of the body against cancer, and we must estimate the reported recoveries after amputation of the breast. Should not a certain proportion of them be credited possibly to the natural defenses of the body? The usual three years' of period recovery he considers a mistake, and he shows cases illustrating the vagaries in development and appearance of tumors diagnosed as malignant. One of these disappeared without treatment, but recurred afterward in other parts of the body after a long lapse of time. Others were not operated and disappeared. The consensus of medical opinion, however, is, he says, that 85 per cent. of breast tumors are malignant and the radical operation is in vogue though not always justified by the pathologic findings. He wishes to state his opinion as to the radical operation. It is mandatory without exception, but disfiguring operations should be avoided unless unequivocally necessary. The procedure which most appeals to him in dealing with benign or relatively benign tumors of the breast is the plastic resection of Dr. J. C. Warren and Dr. W. L. Rodman. These methods, or some modification of them, have been employed by him for some years with results most satisfactory both to his patients and to himself.

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The Sand-Fly in Pellagra.—S. J. Hunter, State Entomologist, Lawrence, Kansas, (Journal A. M. A., February 24), has, at

the instance of the state board of health, made a study of the occurrence of the sand-fly in connection with the first reported cases of pellagra in Kansas. A former extended opportunity for study of this insect in Iowa had made him familiar with it. He found it abundant in the immediate neighborhood of Oswego, where the cases occurred, and the lines of investigation he followed were transfusions to guinea-pigs and monkeys and transference of flies to the pellagrins to monkeys and guinea-pigs. The transfusions and inoculations gave no positive results, and he therefore studied particularly the role of the sand-fly according to Sambon's theory. The only species found in Kansas thus far is Simulium vittatum as determined by Johannsen. All the reported cases of pellagra except one are from territories where this insect is found and that one had spent the year of 1910 in the South. In his experiments 1.282 live sand-flies were used and the patient, a woman of about 35, readily did her part in the study of the subject. The plan was to divide the number of flies intended for each experiment into two lots, the one lot to be exposed to the pellagrin and the other to the control. Ten guinea-pigs and two monkeys were used, the temperature being taken morning and evening daily. As only the females bite, it is necessary to note their proportion in the flies used, which was 42 per cent. Early in the season the flies did not seem to bite the patient, but after October 12, they bit freely. Repetitions of the experiments were made daily during the period from August 24 to November 4. On November 7, the male monkey became less active and on the 8th he seemed decidedly ill, in the afternoon becoming lax and motionless save for a rapid respiration. Its temperature was 103.6. or a little above normal. He continued about the same until November 12, refusing all food but drinking water freely. He was chloroformed, autopsied and the brain and spinal cord are now being studied by the nerve specialist. The work has served to establish a satisfactory technic and has furnished material for further studies. Measures are being taken to continue the study with a larger number of monkeys to determine the valadity of the Sambon theory of pellagra.

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Penetrating Wounds of the Abdomen.—Dr. J. R. B. Branch, Macon, at the meeting of the Medical Association of Georgia, at Atlanta, said:

I have collected fifty cases from the Macon Hospital records, showing a mortality of 52 per cent. These patients were operated on by six different surgeons and we have reached the following conclusions: 1. In all penetrating wounds of the abdomen

seen within twelve hours from the time of the injury, operation should be done as promptly as is consistent with good technic and skilful work. 2. The incision should be made large enough to insure a good survey of the abdominal viscera without unduly exposing them. 3. Extensive evisceration is unneccessary and unjustifiable, greatly increasing the mortality. 4. Unless the peritoneum is extensively soiled, intestinal content should be wiped away with salt gauze sponges; irrigation does more harm than good. 5. If the closure of the perforation, or destruction of the blood-supply threaten seriously the usefulness of a portion of the bowel, resection should be done. 6. If the peritoneal cavity is soiled extensively drainage is safer; otherwise the incision may be closed. 7. Post-operative treatment is very important. Fowler's position should be maintained.—Journal of the New Jersey Medical Society.

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Prevention of Shock.—Dr. J. H. Carstens, of Detroit, contributed a paper on this subject at the annual meeting of the Obstetricians and Gynecologists, in which he drew the following conclusions: (1) By simplicity and tact in management before operation much shock could be prevented. (2) The surgeon should have everything ready in the operating room, and the anesthetic should be started immediately. (3) All the necessary ligatures and instruments should be at hand, so that there need be no delay during the operation. (4) One should analyze the case thoroughly beforehand so that he might know exactly what he was going to do, and how he was going to do it, and what complications might arise. (5) Two quarts of salt solution in the form of an enema should be given, or given hypodermically as soon as the operation was finished. (6) The patient should be kept free from pain for twenty-four hours after the operation.—Journal of the New Jersey Medical Society.

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Iodine in Skin Sterilization.—Dr. J. Wesley Bovee, of Washington, D. C., summarizes his observations and experiments as follows: (1) So far as could be ascertained by culturing epidermic scrapings, weak dilutions of iodine, even to 5 per cent of the official tincture, thoroughly sterilized the surface of the skin for a period of time lasting from two minutes after its application to fifteen minutes after. While this inhibitive action of absolute alcohol was quite potent, this property was greatly enhanced by the addition of iodine to an equivalent of 5 per cent of the U. S. P. tincture. (2) Pubic hair placed in iodine dilutions of 5, 10,

20, 30, and 40 per cent strength (of official tincture) respectively, for two, three, five, eight, ten, twelve, and fifteen minutes respectively, all showed growths after three days incubation, while using 50 per-cent dilutions under the same conditions practically always prevented growths. (3) Control scrapings of skin taken from the abdomen above the umbilicus over periods of time varying from two minutes to two hours, when 40 per cent-dilutions were used, always showed negative results as to colonies. (4) Cultures from hair and skin that had been subjected to 50 per-cent dilution of tincture of iodine never produced growths. (5) Tincture of iodine diluted with an equal amount of absolute alcohol might be considered reliable as a local application in preparation of the skin or mucosa in any part of the body. Dilutions of less strength were unreliable if hairs or large hair follicles were in the field of operation. (6) The 50 per-cent dilution of tincture of iodine, if not carelessly applied, is not liable to injure the skin.—Medical Record, October 14, 1911.

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OBITUARY,

Edwin E. Richardson (license, Kansas, 1901); for thirty-eight years an eclectic practitioner of the state; died at his home in Hutchinson, January 31, from angina pectoris, aged 73.

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Dr. C. W. Rennick, born in Covington, Indiana, December 7, 1870, died January 25, 1912. He was educated in the common schools, became a telegraph operator, put himself through school working at the key, graduated from the University Medical College, Kansas City, Mo., in 1895, practiced at Garden City, Mo., 1897 to 1898, and in Cherryvale, Kansas, 1898 to 1901, at which time he was an active member of Allen county medical society; and held a position on the hospital staff. From 1901 to 1908 he practiced at Gas City, Kansas.

In 1908 he bought a farm of 240 acres ten miles southeast of Wellington, and essayed to enjoy a rural, agricultural life, but his neighbors gradually drew him into practice. At the time of his illness he was a very busy and much loved physician, doing a large practice.

A funeral service was held at the home, "Highland Park Farm", Jan 26, and the body taken by his mother to Cherryvale, Kansas, for burial.

He was an active member of Sumner County Medical Society.

T. H. JAMIESON.

Communications.

Editor Kansas Medical Journal, Kansas City, Kansas.

Dear Doctor:—

A thing of much importance to the physicians of Kansas is the question of pauper practice. Our county society as well as individuals have investigated the matter thoroughly here, and find that we have no legal standing whatever. A township trustee may instruct us to look after a worthy poor person, and O. K. each visit, yet the Commissioners may allow us what they please or nothing; yet at the same time the County may be paying house rent and grocery bills for this same sick person. No one ever heard of a merchant furnishing goods and the county turning down the bill. The injustice of the present situation is plainly apparent to any right-minded man. No one can make a legal contract which will bind the County to pay us a cent for medical services rendered a pauper, even when the County is paying all other bills for him; not even one of the Commissioners. The contract must be with all three commissioners to be legal and stand in court. I don't think the Commissioners are any more to blame for the present state of affairs than the physicians, because I have seen bills presented by some member of our profession reading from one to five visits daily for a month or more and it is hardly reasonable to suppose that the commissioners would pay such a bill. The only way to remedy this is to go after our legislature and have a bill passed that will protect us.

We in Wilson County would like to hear from others and suggestions for the proper kind of a bill that would protect the medical profession, yet at the same time protect the state from exorbitant fees. Seems to me that our attorneys might draft a bill and the state society act on it at our spring meeting.

Very truly,

E. C. DUNCAN,

Fredonia, Kansas, February 13, 1912. Secretary County Society.

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MISCELLANEOUS.

If a body meet a body
Coming thru the rye,
Can't a body kiss a body
For fear of bacilli?

—Medical Review of Reviews.

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Enlarged Tonsils and Crime.—The latest theory, which hails from Washington, is that enlarged tonsils are a frequent cause of

juvenile crime. The opinion of so distinguished a criminologist as Judge DeLacy upon this subject is stated to be backed up by many leading members of the medical profession in Washington, one of whom, Dr. C. R. Dufour, of Georgetown University Hospital, is said to have examined a large number of mentally backward and incorrigible children and to have discovered in them the existence of enlarged tonsils and adenoids. Some of these were taken and the morbid growths were removed, after which considerable improvement began to show itself in their character and conduct. Any source of reflex irritation present in a child of neurotic or ill-balanced temperament cannot but react unfavorably upon its mental life, so that its removal might be expected to have a good influence in preventing the development of undesirably traits.—Medical Press, London.

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Apoplexy and Insurance.—Prochazka says that the real cause of an apoplectic stroke is either a disease of the arteries, resulting in a cerebral hemorrhage or a disease of the heart, resulting in a cerebral embolism. In either case some accident may be the exciting cause, or at least play a significant role in the occurrence. In cerebral hemorrhage the breaking of the weakened vessel may be caused by undue exertion, by abrupt change in temperature of the body, by the rise of blood pressure following fright.

Of course, concussion of the skull and brain may have a similar effect. Cerebral embolism may follow injury involving the thorax, and psychic excitement or physical strain leading to overactivity of the heart, etc. Any of these occurrences may be looked upon as determining the onset of an apoplectic stroke, and, therefore, they must be considered in all claims for indemnity by persons insured against injuries and accidents.—Medizinische Blatter.

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NEW AND NON-OFFICIAL REMEDIES.

Since the publication of New and Non-Official Remedies 1912, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association, for inclusion with "New and Non-Official Remedies."

Lactic Bacillary Tablets-Fairchild, are made from a practically pure culture of the **Bacillus bulgaricus.** They are designed for internal administration in the treatment of intestinal fermentative diseases by the Bulgarian bacilli, with the design of accomplishing the acclimation of the bacilli in the alimentary

tract, so as to secure their characteristic action against putrefactive fermentation by the production of lactic acid. One or two tablets before or after meals. The diet should not contain an excess of proteid, but should afford sufficient sugar. Fairchild Bros. & Foster, New York (Journal A. M. A., January 20, 1912, p. 191).

Salvarsan (Arsenphenol-amin hydrochloride, arseno-benzol, "606", is 3-diamino-4-dihydroxy-1-arseno-benzene hydrochloride, $HCl.NH_2.OH.C_6H_3As:As, C_6H_3.OH.NH_2.HCl+2H_2O$, corresponding to 31.57 per cent arsenic (As). It is marketed in hermetically sealed tubes each containing 0.6 gm. (10 grains) Salvarsan. Salvarsan is a yellow crystalline, hygroscopic powder, very unstable in air. It is readily soluble in water, yielding a solution with an acid reaction. The addition of sodium hydroxide solution to an aqueous solution of salvarsan precipitates the free base ($NH_2.OH.C_6H_3As:As.C_6H_3.OH.NH_2$) which redissolves when more alkali is added.

It is given to adults in doses of 0.3 to 0.6 gm. (5 to 10 grains); for children the dose is from 0.2 to 0.3 gm. (3 to 5 grams). In infants doses of from 0.02 to 0.1 gm. (⅓ to 1½ grains) may be used. For a subcutaneous and intramuscular injection a suspension in a neutral fluid is commonly employed. This suspension is prepared as follows: The weighed amount of salvarsan is triturated with 0.35 cc. normal sodium hydroxide solution to each 0.1 gm. salvarsan. To this liquid a solution of 0.1 gm. cc. of normal sodium hydroxide solution for each 0.1 gm. of salvarsan in 8 cc. of sterile water is added drop by drop until the liquid is exactly neutral to litmus paper. If the neutral point is passed the excess of alkali must be carefully neutralized by a weak solution of hydrochloric or acetic acid. Subcutaneously, salvarsan may also be administered in form of oily suspensions.

These suspensions should be injected at once, using a syringe with a very thick platinum needle.

For intravenous injection a clear alkaline solution is prepared as follows: The weighed quantity of salvarsan is triturated with 0.7 cc. normal sodium hydroxide solution for each 0.1 gm. of salvarsan and then more of the alkaline solution is cautiously added until complete solution occurs.

This solution is diluted with from 100 to 250 cc. (3 to 8 ounces) of sterile physiologic salt solution (0.9 per cent.), and filtered through a sterile filter.

The contents of a tube should be used at once after opening and under no circumstances should the contents of a tube damaged

in transportation or any remants of the powder from previously opened tubes be used. Victor Koechl & Co., (Journal A. M. A., January 20, 1912, p. 191).

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Metchnikoff Never a Medical Student.—The Sun for December 17, 1911, summarizing from the Independent, points out that Elie Metchnikoff, successor of Pasteur, although the foremost of medical men, was neither born a Frenchman nor trained as a physician. Like Pasteur he entered, the realm of medicine by crossing the frontier of another science. Pasteur was a chemist, an inorganic chemist at that, and was running down the cause of asymmetry in crystals when he found himself over in the field of biology. He had been engaged in separating the leftward skewed crystals of tartaric acid from those that skewed to the right by picking them out of the mixture by hand. He discovered that he could throw the burden of selection off on an agency whose time was less valuable, namely, the yeast plant, which has an appetite for one kind of crystals, but disdains the other. This led him to the germ theory of life and of disease and enabled him to save millions annually to the farmer and stock raiser and unnumbered human lives. Metchnikoff's experience was similar. He was a zoologist, less interested in man than in the invertebrates, devoting his time to the study of the minuter forms of life on the barren steppes of Russia and in Mediterranean waters. It was in Italy at Messina in 1882 that he made the discovery which led him to fame as one of the benefactors of the human race. He was investigating the digestion of marine invertebrates when he got the clue to the protective action of the blood in the higher animals and man, and in 1884 he outlined his theory of inflammation. This was, in short, that the congestion of the blood at a wound was due to the efforts of the leucocytes or white blood cells to overpower the invading microbes. The value of this discovery was recognized immediately by the two foremost authorities in biology, Virchow, the German, who had discovered the leucocytes, and Pasteur, the Frenchman, who had discovered the microbes. Metchinikoff had now found the missing link which brought these two discoveries together and showed their meaning. In 1888 Metchnikoff was called to the Pasteur Institute, and in 1895 became its director. Like Agassiz, he has "no time to get rich." At his home in the suburbs of Paris he sets an example of the plain living his advocates, supplementing the meagre salary given at the institute by the income of a small estate in Russia. The $20,000 he received from the Nobel Foundation he devoted entirely

to the furtherance of his researches in longevity. M. Metchnikoff had given the best possible proof that he has no personal aversion to women who enter his profession, for he married in 1875 as his second wife a Russian bacteriologist of distinction. He dedicated to her in his first volume of Optimistic Studies, and in it he cites her experiments on the growth of microbe free tadpoles.—N. Y. Medical Journal.

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DOCTOR'S AND LAWYER'S FEES.

In a conversation some time ago a prominent lawyer remarked to a physician of repute that the estate of a well-known "captain of industry," amounting to some forty millions, would bring the lawyers about a million dollars as fees. The doctor asked the lawyer:

"Suppose the man were dying, but there being a chance of saving his life by a difficult operation, a surgeon should operate and save his life, would that surgeon be justified in sending in a bill for $100,000?"

The immediate answer was: "Certainly not."

"Well," asked the doctor, "how is it that the lawyers can charge such large fees?"

"Because," replied the advocate, "a lawyer's fees are fixed by the courts."

And the celebrated physician, whose office fee of ten dollars is often grudingly paid, remarked:

"You lawyers have solved the problem of self-preservation, while we are spending our time in the preservation of others."—Journal of the Medical Society of New Jersey.

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Artificial Feeding.—The following are the conclusions of an article by F. C. Neff, Kansas City, Mo. (Journal A. M. A.,) on the artificial feeding of infants, based on a study of 100 infants during the first three months of life. They were all institutional cases: "1. The average length of time before an infant regains its initial weight is eleven days. 2. The rectal temperature of infants under 6 months of age is 98.6 F. This method of taking temperature should be employed exclusively, so as to avoid the misunderstanding which often exists regarding the indefinite mouth

and axillary readings. A temperature of 99 F. or above is suspicious and should be regarded as pathologic. 3. Peptonization of milk showed no advantages in the new-born, but is occasionally beneficial in older infants. 4. Buttermilk is a useful food in some cases, even in the first weeks of life, and where breast milk is not available should be tried in cases of fat intolerance and in enterocolitis. 5. Some infants showed increased weight when fed on skimmed milk, which, when suitably diluted, can be made the basis for fat and sugar additions. 6. Malt soup is the food that in our experience proved the best milk preparation. 7. Casein milk has a useful but limited field in catarrhal enteritis, the ailmentary intoxication of Finkelstein. 8. Maltose answers all the requirements for a sugar in infant-feeding." Formulas for malt soup are given in the text.

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CLINICAL NOTES

In eclampsia when the cervix is rigid and it is found imposible to empty the uterus without severely lacerating it, vaginal Cesarean section is indicated. The wound in the cervix and uterus is best closed with chromicized catgut No. 2. It is preferable to leave the vaginal wound open about an inch in the median line and drain between the anterior wall of the uterus and bladder. The drain should be removed on the fifth day.—Ralph Waldo—International Journal Surgery.

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In injuries to the cord, if the tendon reflexes are preserved, even slightly, the surgeon may exclude complete and irremediable severance to the cord; but the total loss of these reflexes during the first few days is not conclusive, as the loss may be transitory.

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In performing external esophagotomy, the trachea is the guide for finding the esophagus. It is easy to remember that there is nothing but the esophagus between the trachea and vertebral column.—American Journal Surgery.

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Some apparently inoperable carcinomata of the cervix will yield remarkably to repeated cauterization with the actual cautery and zinc chloride.—American Journal Surgery.

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THE IMPORTANCE OF LABORATORY DIAGNOSIS.

DR. H. MILTON CONNER, Topeka, Kansas.

Read before the Northeast Kansas Medical Society, Feb. 8, 1912.

In this day of progress in medicine when it is charged by many that the practice of medicine has "gone to seed" on laboratory diagnosis, it may seem to some, useless to read a paper, further calling attention to, and emphasizing the value of the clinical laboratory.

But I, in common with many others, am so impressed with the value of this most important aid to diagnosis, that I cannot but feel that it cannot be too forcibly emphasized.

To begin with, let us consider a few conditions in which the laboratory examination of the urine is essential.

Altogether, the urine is far more frequently examined in the laboratory than any other secretion, excretion or body fluid or tissue, but still far too infrequently by a large number of us. Too, when it is examined, reliance is too often placed on the chemical examination only, neglecting entirely the microscopical side of the work. I think that if we had only the one method of examining the urine—chemical or microscopical—that in disease of the urinary apparatus, the microscopical examination would be of the greater value in diagnosis.

How can the clinician make the distinction between diabetes mellitus, that most dreaded disease and diabetes insipidus or polyuria from some other cause, except by means of the urinary examination? How many cases of chronic interstital nephritis with the passage of large quantities of urine of low specific gravity have been treated for diabetes insipidus or hysteria? In this case more than a chemical examination is required, for unless albumen appears in appreciable quantities in the urine of the

victim of interstitial nephritis—as it very frequently does not—then the diagnosis would be at fault from a chemical examination only. The history of the case with the heightened arterial tension and stiff vessels, in conjunction with the laboratory examination, showing hyaline and granular casts, low specific gravity and the presence of albumen, sometimes only the merest trace, clinches the diagnosis. How many cases of lumbago have been diagnosed and treated for kidney disease, when an examination of the urine would have shown the absence of the latter complaint?

Again, we see cases of cystitis called kidney disease, on account of the reliance on the chemical examination only. We may find albumen in the urine of a severe cystitis, from the purulent exudate, but a microscopical examination will usually clear the situation by the failure to find casts and kidney epithelium in cystitis.

Examination of the sputum and swabs from the throat are also of very great value. What progressive physician attempts to make a certain diagnosis between a streptococcic and diphtheritic pseudo-membrane without a laboratory examination? What conscientious practitioner attempts to make a positive diagnosis of tuberculosis of the lungs, without an examination of the sputum? We all know that formerly many cases of chronic bronchitis were called consumption, and vice versa.

The stomach contents are far too infrequently examined in the laboratory. Many cases of carcinoma of the stomach are diagnosed and treated for chronic indigestion, when an examination of the stomach would reveal in a large percentage of cases carcinoma, the absence of free hydrochloric acid, with the presence of blood, lactic acid and the Oppler-Boas bacillus. The distinction between ulcer and carcinoma of the stomach or ulcer and gastric neuroses can also best be made by the laboratory examination of the stomach contents.

Probably one of the most neglected excretions from the laboratory standpoint is the feces. This may be partly accounted for by the disagreeableness of the work, but partly also because we are likely to feel that the examination of the feces is not of much value. The truth is that it is very important.

Many times, blood can be detected in the stools in cases of carcinoma or ulcer of the stomach, when it cannot be found in the stomach after several examinations.

Much can be found out in regard to the efficiency of the digestive process, by an examination of the stools. If large amounts

of starch or fat are found constantly, we have reason to think the digestion of those substances is faulty, and act accordingly.

The presence of the typhoid bacillus in the stools of typhoid fever, the bacillus dysenteriae in bacillary dysentery, the entameba histolytica in amebic dysentery, the bacillus tuberculosis in intestinal tuberculosis are only a few examples of the diagnostic value of the laboratory examination of the feces.

The microscopical examination of tissues is also of the highest value, both for diagnosis and prognosis.

We all know that a considerable number of cases of carcinoma of the uterus are sacrificed every year, whereas, an early examination of curettings, or a piece of tissue excised for the purpose, would enable a diagnosis to be made in time for a successful operation.

Again, many cases of malignant growth of other regions could be diagnosed in time for successful treatment, if a piece of the tissue were excised and sent to the laboratory.

However, the suspicion of malignancy is not the only reason for having tissues examined. I have in mind a case of a small oval body about one by one-half inch, apparently a tubercular lymph node, removed from the cervical region, which was sent to me for diagnosis by one of our surgeons. It was full of cheesy material, such as is found in tubercular lymph nodes that have undergone softening. An examination of the semi-fluid material was made for tubercle bacilli, but none were found, as frequently happens in the so-called pus in tubercular lesions. Sections were made and presented no evidence of tuberculosis but the entire cavity was lined with a stratified squamous epithelium, and the diagnosis of branchial cyst was made. In this case the prognosis, subsequent treatment, etc., depended very much on the laboratory diagnosis.

In all cases of a suspicious lesion of the breast, uterus, face, lip, tongue or any other easily accessible organ, a laboratory diagnosis should be made, and the treatment based very largely on the findings of the laboratory.

Of course, this usually necessitates the sending of the specimen to some diagnostic laboratory, as the average man in general practice hasn't the time to devote to this line of work, even though he were equipped with microscope, microtom, and other necessary apparatus and reagents. Besides, this work would come so infrequently in the practice of the busy physician, that he would not feel capable to interpret the findings unless he were specially equipped in this line.

One of the most neglected, but important fluids of the body, from the standpoint of laboratory diagnosis, is the blood. Although a large amount of work is done in this line, still it is not nearly commensurate with its importance. Since the examination of the blood has become a matter that is resorted to by almost every progressive physician the term malaria has ceased to be the dumping ground for our inability to make a diagnosis. The term typhoid malaria has also ceased to be the scapegoat of poor diagnosis because the doctor knows that someone else may come along and do a Widal test or examine for the plasmodium and show the incorrectness of his diagnosis.

The primary, or essential anemias, have been separated from those due to other diseases, otherwise called the secondary anemias and the prognosis and treatment regulated accordingly. A certain diagnosis of chlorosis, pernicious anemia, or the leukemias, can be made only by means of the laboratory, in conjunction with the clinical examination. When we remember the great resemblance of the gross lesions that are apparent clinically between leukemia Hodgkin's disease and tuberculosis of the lymph glands, we cannot fail to recognize the value of the ability of the laboratory to make a positive diagnosis of leukemia.

Again, certain diseases, clinically very much alike, can very frequently be distinguished by the presence of leucocytosis in one and its absence in the other.

The prognosis in some diseases, such as lobar pneumonia, can be obtained in many cases from the leucocyte count. The distinction between bronchial, and renal or cardiac asthma, can often be made by the differential leucocyte count, the former condition showing a marked eosinophilia, while the others show no characteristic change.

The Widal test for typhoid of course, needs no mention, as it is recognized by almost all phyiscians as of the greatest value in diagnosis. Another method of diagnosis in typhoid that may be done much earlier in the course of the disease is a culture of the bacillus obtained from the blood.

We might enumerate a very large number of diseases that may be diagnosed, or at least an aid to diagnosis obtained, by examination of the blood, but those mentioned ought to serve the purpose of emphasizing the value of its examination in any obscure case, and in many cases apparently clear clinically.

But probably the most important procedure in the examination of the blood is the Wasserman test for syphilis. I say most important, because it is one of the most accurate methods of

diagnosis in medicine to-day. A positive Wasserman reaction is almost certain evidence of syphilis, barring a few diseases such as leprosy, scarlet fever, frambesia, trypanosomiasis and possibly malaria, which in most cases are not likely to be confused with syphilis anyway. To emphasize its value, I wish to report a case of peculiar clinical value on account of the very typical symptoms, and one which emphasizes very strongly the value of the Wasserman test. Mr. B. developed a small sore on the penis two weeks after exposure. A week later, he went to a physician who consulted me in regard to the advisability of a Wasserman test. I told him that a Wasserman at that early stage would probably be of little value, as it would almost certainly be negative in so short a time after the appearance of the initial lesion. However, the patient insisted on a Wasserman a few days later. This was negative. The chancre could not be examined for the treponema pallidum, as it had been cauterized by the patient himself. In the course of six weeks, the sore was healed perfectly and no further manifestations were seen except a slight enlargement of the inguinal glands, which, however, he insisted he had always had. Six weeks after the first Wasserman, I did another, which also was negative. Careful watch was kept for the secondary manifestations, but none appeared—no skin eruption, mucous patches, headache, falling of the hair, pain in the joints, or any other of the secondary symptoms—except a slightly suspicious throat. Two months after the second Wasserman, or four months after the beginning of the disease, I did a third Wasserman. This time it was distinctly positive, notwithstanding the fact that there were almost no clinical manifestations and certainly none on which a diagnosis of syphilis could be based. The diagnosis by the Wasserman test was proven to be correct in this case by the fact that the patient could take five grains of the protoiodide per day without manifestations of mercurial poisoning.

Many other cases could be cited which would show the very great value of the Wasserman reaction, but this case serves the purpose. In fact, it is so valuable that nearly all of the men who are giving salvarsan extensively, are doing so only after a positive Wasserman, and also doing a Wasserman, or a series of reactions, as a means of control. A persistently negative Wasserman test when all the clinical symptoms have disappeared, is the only safe criterion by which to judge, whether or not, the case is cured. A positive Wasserman, even when the symptoms have all disappeared, is the signal for further treatment. A great deal of discussion, in regard to the Wasserman test's being non-speci-

fic has taken place, but this does not detract from its values as a diagnostic agent. It is still by far the most accurate method of diagnosis we have, and should be resorted to in every case. Practically every case of untreated secondary or tertiary syphilis reacts positively. Of primary cases, about sixty per cent. react positively. Consequently at the time when the diagnosis is most obscure the Wasserman test is almost absolute when treatment has not been administered. Where treatment has been administered in cases of syphilis, it also reacts positively in a great majority of cases.

The great disadvantage of the Wasserman test is the fact, that on account of the large amount of work connected with it and on account of the laboratory animals required, it cannot be done by the busy doctor in his practice, because he would necessarily have to refuse other business while he is doing it, consequently it will probably never be done very extensively by the general practitioner, but will be left to the laboratory worker.

In conclusion, I wish to again urge upon the profession, the great value of the diagnostic laboratory in all of its phases, only a few of which, I have discussed.

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MEASLES—A SERIOUS DISEASE.

LLOYD A. CLARY, B. S., M. D., Elbing, Kansas.

Read before the Marion County Medical Society, March 13, 1912.

Measles is a disease that we are too prone to ignore, one that we are apt to class among the mild children's diseases and to speak of lightly, as being of slight importance. It is a disease that we, even though we are supposed to be medical men and to know something about it, are very likely to look upon as a joke. Because measles is decidedly no joke, but a dangerous disease, serious in its complications and sequelae, I have taken it for my subject believing it a topic worthy of discussion.

As to the cause of measles we all know that there is a specific virus that causes the diseases, but just what this virus is and what name we shall give to it is still in doubt. There has been a lot of work done during the past year, on this subject, a number of experiments having been conducted by Anderson and Goldberger working in the Hygienic Laboratory of the United States Public Health and Marine Hospital Service in Washington. Among other things they have given us some information on the filterability, resistence to heat, drying and freezing of the virus of

measles, but they have not isolated this virus sufficiently to determine just what it is. It is probably a micrococcus.

The infectivity of measles is well known, but just how virulent is the virus of measles is still a disputed question. Anderson and Goldberger, in the experiments above referred to, demonstrated the infectivity of measles among monkeys by "contact." They also clearly demonstrated that the mixed buccal and nasal secretions were infective on the 4th and 6th days of the disease, and that this infectivity was due to a living virus susceptible of transfer from monkey to monkey by blood inoculation. These experiments, carried on during June and July 1911, are claimed to be the first that convincingly demonstrate the virus of measles in buccal and nasal secretions. These experimenters show that the blood of measle patients loses its infectivity about 24 hours after the appearance of the eruption and that the blood is infective from just before until 24 hours after the eruption. They have shown that the combined buccal and nasal secretions are not infective in all cases. It also seems from their work that the scales are non-infective, this latter point having been claimed before by a number of investigators. We may draw the conclusion from all this that measles is an infective disease and that the patient should be isolated, and that the secretions from nose and mouth especially, should be taken care of to prevent the spread of the disease.

Right here it might be of interest to remark that T. J. O'Meara, in the Medical Press and Circular, London, for Sept. 6th, 1911, says that immunity against the toxemia of measles is gradually acquired in insular communities where isolation is practiced. This is shown on Cape Clear Island. He points out that the course of the disease during the past thirty years shows this immunity is hereditarily acquired, the death rate having fallen in proportion to the percentage of parents who had measles before marriage.

In measles one attack does not afford immunity, as many as four attacks having been recorded in one individual.

As to the pathology of measles. In uncomplicated cases we have no pathological lesions. The only post-mortem changes found, as a rule, are those of catarrhal pneumonia and acute nephritis. However, all the internal organs are gorged with blood, minute hemorrhages are found on their surfaces and croupous pneumonia may be found involving a portion of a lung. We see from this that something has taken place within the body that is

not natural and it should lead us to regard this affection as a disease of some consequence.

The diagnostic points in this disease are: or should be, so well understood, that they require no discussion. When found in typical form it is comparatively easy to diagnose, a simple glance at the patient often sufficing to tell the experienced practitioner what he has to deal with. The symptoms of a "cold," a dry, metallic cough, the coryza, slight fever, photophobia, and the eruption itself, starting on the forehead and neck and spreading down over the body, forms a picture generally easy to recognize. Koplik's spots, which are reddish papules with a peculiar bluish-white speck in the center of each and which appear on the buccal mucous membrane or soft palate, are of great diagnostic value. They can be seen only in daylight, and for this reason we many times do not find them on our first visit. Still, it is not hard to make the diagnosis of measles provided the case is well marked. But sometimes we have measles associated with chicken-pox or scarlet fever and then the task is not so easy. As they are all diseases which should be quarantined, however, we can at least do that much to protect the community while finding out just what name to apply.

We are not going to attempt to describe the clinical course of a case of measles. Every physician knows, or should know, all that is necessary regarding this phase of the subject, We expect to take up the subject of complications and try to bring out the fact that measles is serious and should be so regarded.

We have heard physicians laugh about measles and say that the disease did not amount to much and that there was no use to quarantine the patients. We have also heard mothers say that they did not care if their children did take the disease as they were almost sure to have it sometime or other and had better have it while young. They even seemed to place their children in the way of those already infected so that the children would catch it and thus get the thing over with as soon as possible. Now on the part of these mothers we can blame them very little. But the doctors who carelessly let measles spread and who make light of it are doing that which they should be ashamed of and which is little short of criminal. How often we hear someone say: "Yes, my sister is hard of hearing. She has been that way ever since she had the measles."

This thing is too common. You have all seen and heard it. There is no excuse for it except ignorance. We must realize that measles is dangerous and we must impress upon the laity if we

are to do away with all the wreck and ruin that is sure to follow measles. When people find out just how serious a disease measles is we may hope for better conditions. Until that time the children whose hearing is impaired, whose eyesight is ruined or weakened, who have tuberculosis and "weak lungs," following measles will continue to grow up among us and help to swell the crowded ranks of the defectives, the "weak sisters" of life.

Turn to De Schweinitz and Randall's American Text Book of Diseases of the Eye, Ear, Nose and Throat and glance through its pages in search of measles and its effects. You will find it stated that stricture of the nasal duct may follow measles, due to inflammation of the nasal mucous membrane. Again you will see that optic neuritis is observed in the great variety of infectious diseases, and is commonly noticed in the course of measles. In treating of inflammation of the middle ear, these authors state: "The acute affections of the middle ear come most frequently by extension from the naso-pharynx. Consequently, the exanthemata, and especially scarlet fever, are among the most frequent causes of a systemic nature. A large percentage of the inmates of the institutions for the deaf date their infirmity from an attack of scarlet fever in childhood. In measles the ear is still more frequently affected. It has recently been shown that the ears are probably involved in every case of measles. An exudation containing the specific organism of measles is formed on the lining mucous membrane of the tympanum by the eruption. But unless this be mixed with one of the pyogenic germs, this exudation is rapidly absorbed without perforation of the drumhead and without injury to the hearing."

In another place in giving the etiology of middle ear trouble as related to various diseases they give us these significant figures: "Solmonson found deaf-mutism caused by measles in 5.6 per cent; Hartman, 3.6 per cent. Tobeitz found otitis media in 21.9 per cent in convalescent children. Of 22 children dying from measles, the ears of 17 were examined post-mortem, and in every one the mucous membrane of the middle ear was found to be diseased, although in only 7 of them had there been any clinical manifestation of ear-complication."

Looking at the subject in this manner—in retrospect as it were—we begin to realize that here we have a disease worthy of serious thought. When we look at the simple case of measles it looks so truly simple that we are apt to forget these sequellae.

An epidemic of measles in our army occurring at Columbus, Barracks, Ohio, last year in which 183 cases developed, showed

a death rate of 8.2%. The following complications occurred during this epidemic: broncho-pneumonia, 23; pleurisy with effusion, 11; otitis media, 13; mastoiditis, 3; meningitis, 1; pericarditis with effusion, 3; abscess of lungs, 2. At autopsy in one case a large tuberculous abscess was found in the apex of each lung, and two had healed tuberculous nodules. The deaths in this epidemic were practically all from some lung involvement, one, however, being from meningitis following involvement of the mastoid.

Broncho-pneumonia is the most frequent complication of measles. Other complications are catarrhal or membranous laryngitis, occasional edema of the glottis, ophthalmia, involvement of cervical glands, otitis, cancrum oris and diarrhea. The health of the child is many times impaired after an attack of measles, and it is during this period that we find whooping cough, diphtheria and nephritis. Later, an acute tuberculosis may arise, as measles leaves a soil very favorable to the growth of the tubercle bacillus.

Our own State Board of Health is doing a lot to teach the people the seriousness of measles, and in its Kansas Health Almanac for 1912 measles occupies a prominent place. In the bulletin issued by this department we find these statements: "It (measles) causes in the United States nearly three times as many deaths as smallpox, and nearly as many as scarlet fever.

Measles and whooping cough together cause nearly as many deaths as diphtheria. The records of the State Board of Health show that for the past four years the death-rate from measles has been six times greater than from smallpox, and the returns for the month of April, 1910, also show that the actual number of deaths from measles in the state during that month was more than that from diphtheria, scarlet fever and small-pox combined. The failure to promptly recognize the beginning of pneumonia in many cases of measles may result in the death of the patient, who could have been saved had proper precautions been taken."

This bulletin also graphically brings out the fact that measles is vastly more fatal in children under five years of age. Could we get the parents to realize this important fact there would be just that one more incentive for care in keeping the children from being exposed to measles needlessly.

Before the State Board of Health required us to quarantine measles there was some slight excuse for our lack of care, but now, since the State Board has ruled that all cases of measles must be

effectively isolated and quarantined, we have no excuse whatever for failing to give our measles patients the care they require and the rest of the community the protection that is due it.

As for the treatment of measles we will say but little. Good nursing is of greatest importance and drugs little needed, except for complications. We should always be on our guard and any lung involvement given prompt attention. Frequent examinations with ear speculum is the only way to detect ear complications in their incipiency. Baginsky states that local disinfection seldom does much good in measles otitis until after perforation, when suitable measures usually lead to rapid cure. He says that in case of high fever of symptoms of meningitis accompany the otitis, the membrane should be incised without delay. Diphtheria some times accompanies measles and this combination is very dangerous for we are apt to overlook the diphtheria. If we find the diphtheria bacilli, antitoxin should, of course, be used.

Every patient with measles should be quarantined, the other children of the family kept away from public gatherings, the parents instructed as to the proper care and the public taught that it is a disease of gravity and not a simple "breaking out."

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ERRORS OF REFRACTION CAUSING NEURASTHENIA AND EPILEPSY.

CLIFFORD P. JOHNSON, A. B., M. D., Coffeyville, Kansas.

Late Instructor in Physiology, University of Kansas.

Read before the Montgomery County Medical Society, Feb. 16, 1912.

The retina of each eye receives a picture which is carried by the nerve to the percipient centers. These pictures, although not identical, are mentally combined and recognized as representing one subject.

This result is accomplished only, when the percipient centers have come to recognize the fact that the vision of an object falling upon the macula of each eye must be mentally interpreted as one object, and not as two. In the course of time this knowledge becomes so automatic that if for any reason the picture of the object looked at falls in one eye elsewhere than on the macula, two images are immediately perceived and confusion results. In order that this parallelism of the visual axes of the eyes shall be maintained with as little muscular and nervous fatigue as possible it is necessary that it should always be present without active, conscious or unconscious effort. The importance of the

fact has long been recognized, and a weakness of the converging muscles has been for many years considered a defect which produced eye strain. The probability that such a defect or that other inequalities of ocular balance might be a source of nervous irritation sufficient to precipitate or produce grave functional nervous disturbances other than asthenopia and headache was first brought before the profession by Dr. George T. Stevens of Belgium in 1883.

Clearness of vision requires that the rays of light which form the image on the retina shall be accurately focused, and this result necessitates that there shall be exercised a suitable amount of accomodation for every given amount of convergence upon looking from a distant to a near object. An error of refraction may blurr the picture for a near as well as for a distant object, but when it is possible to do so the eye brings to its aid the cilliary muscles, and by this means corrects the error of focus and secures a sharp definition. Now, it is an established fact in ophthalmology that headache, mental, physical and nervous fatigue amounting even to confusion and inability to think, may be dependent upon this correction of an error of refraction by the cilliary muscle. These symptoms must be due either to fatigue of the muscular apparatus, or to the nervous fatigue of the central nervous system developed by a constant semi-conscious or unconscious effort to hold the cilliary muscles up to their duty, or it may be, to mental fatigue of the percipient centers due to the difficulty of recognizing a partially blurred image; yet, it is to be remembered that for every effort of accomodation there is associated convergence, associated either from actual correlation of the brain cells or from habit.

The third cranial nerve supplies not only the cilliary muscles, and the sphincter of the iris, but, also the internal rectus, superior rectus, inferior rectus, and inferior oblique, from which anatomical arrangement it is evident that accomodation and convergence are necessarily associated and of equal importance for comfortable binocular single vision.

NEURASTHENIA.

Such cases complain of pain in the occipital region, often of a pain in the back of the neck, not infrequently a pain in the spine, down as far as between the scapulae; often a giddiness, which is never so pronounced that the patient falls, and is most frequently present upon first arising in the morning, in crowded streets, or when looking at rapid moving objects. They are very apt to complain of a sense of confusion in thronged thoroughfares; of being car sick on railroad journeys; of being unable to watch

passing scenery from a railroad train without fatigue, headache and, perhaps, confusion that they are unable to study, or to concentrate their thoughts upon subject matter of the text, or to think logically in connection with what they read; and they do not like to meet and talk to people or to look steadily at any object. These symptoms, when the occupation of the individual is so as to call them forth, slowly increase in intensity, and gradually the headaches are not confined to the occipital region, but become more and more a marked feature of the clinical picture, until, finely, the patient is reduced to a condition of neurasthenia, which compels him to abandon his occupation, retire to some quiet locality, and spend months in allowing his mental nervous equilibrium to re-establish itself. Then only too often upon returning to his usual work the same story repeats itself again and again, until the patient becomes a nervous, querulous, irritable invalid, utterly unfitted for any occupation which requires either the use of the eyes or mental application.

EPILEPSY.

Epilepsy is one of those distressing conditions, whose etiology is generally attributed to heredity. "Direct inheritance is comparatively uncommon, yet the children of neurotic families in which neuralgia, insanity, and hysteria prevail are more liable to fall victims to the disease." The most potent predisposing factor in the production of epilepsy is chronic alcoholism in the parents. Syphilis and alcohol are also direct causes of the disease. Certain local conditions cause epilepsy by reflex action. Besides an error of refraction as a reflex cause of epilepsy; dentition, worms, the irritation of a cicatrix, or some local affection, such as adherent prepuce, or a foreign body in the ear or the nose, have been known to cause the disease.

The history of the following case is an example of a reflex cause of epilepsy due to an error of refraction. Mary N., thirteen years of age, had the following family history; an aunt on her mother's side had chorea. The father's mother was insane. A sister had an error of refraction, but did not wear glasses. The patient had always been well up to her eighth year, when she had epileptic convulsions preceded by a cry, after which she became rigid and had general convulsive movements. She would remain unconscious for some moments, and after recovery from attack was sleepy. She was much more subject to these attacks when she attended school, and they had continued with more or less frequency for five years. She had one slight convulsion on the night following the first day of wearing glasses, after which there were no

more epileptic convulsions. If, then, this distressing neurotic condition can be prevented by the correction of an error of refraction or the removal of some local cause in a few cases, the time and effort put forth to find the genuine cause of reflex epilepsy, will have been well spent.

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SCARLET FEVER—A FEW OBSERVATIONS.

DR. W. L. WELSH, Hazelton, Kansas.

Read before the Barber County Medical Society, Jan. 24, 1912.

Having had a very limited experience with this particular disease; its etiology, symptomatology, treatment and complications being so well known to the profession, I feel it worse than useless for me to attempt anything along that line.

Skeptics are usually of the class called bores, but in the face of this, I shall acknowledge that study and observations has made of me a confirmed skeptic regarding some of the things taught in medicine, especially in the one very important branch, that of bacteriology, and it is of a few observations along this line that I wish to speak briefly.

Thousands of men in every civilized country are occupied in expounding old ideas which are known to be and have been proven erroneous, Many gain fame as well as pecuniary benefits from teaching theories long since exploded. The Darwinian theory of evolution, in which the medical fraternity to a great extent believe, is quite complete up to certain point, The classification and development of bacteria is quite well established, but the origin of the species is not known and no plausible theory is advanced for this very important point in arriving at the definite cause of diseases and the origin of germs, as well as the beginning of the various epidemics. The division line between the animal and the vegetable cell is so indistinct that many verbal wars are waged as to what classification certain cellular bodies belong. This may indicate the way to the missing link and when settled, complete the evolutionary chain.

It may or may not have occurred to many of you that most germs might have a common origin, and that what now are called "species" might come to be known as one of the many stages of development of certain protoplasmic bodies that even now are known to have a cycle of development, and that it is during this cycle of development that many of the germs and bacteria of the

old classification are demonstrable as well as some that are not in the classification.

It is here that I wish to call attention to an observation made during an epidemic of scarlatina, that brings out the point that I desire to make. In the family were some seven or eight children. Two had scarlatina of a moderately severe type; three had it rather light and the others showed no signs of the disease except perhaps a little sore throat. Immediately following this, two of the children that did not have scarlatina, developed typical cases of typhoid fever, and one that had scarlatina moderately severe, together with the mother who had had some sore throat, had inflammatory rheumatism. In trying to study out the connection that the scarlatina had with these diseases following, and having made former microscopic studies with a co-laborer, Dr. H. G. Graham, and having observed the cyclical development of germs from the protozoan, I concluded that in this instance the patients who had had scarlatina of the more severe type had developed in their tissues sufficient antibodies to prevent further development of the organisms, but the ones who had shown no signs of the disease, had in reality had the infection and not sufficient antitoxins generated to retard further development of the organisms and this process had continued to a period when the body was flooded with the typhoid germs and their toxins and the patient succumbed to this particular disease; and likewise, the ones who had had it lightly, in them only sufficient immunity was given to delay rapid development, but even in these the organisms had reached a period in the cycle of development when they came down with rheumatic infection.

This observation led to microscopic study of a certain protoplasmic mass found in most drinking waters and commonly called the amoeba, which is a protozoan and which microscopically resembles the leucocyte of the blood. This study which was carried on over a period of time, proved that this organism had stages of development varying under conditions, and that during this time most of the known pathogenic germs were demonstrable and that during this time the original organism was lost sight of, but that in time they again showed up in countless numbers, and the one conclusion could be drawn, namely, that the cycle of development had been completed and the interval was occupied in making a new bacteriological theory. That this organism, owing to environment and developmental changes, had been in many instances mistaken for a phagocyte, and that instead of the leucocyte flocking to the point of injury as a phagocyte, a scavenger, a life

saver, that it might be this organism coming here simply because the conditions were suitable for its growth and rapid development, and that in many instances the infection came from these bodies and not from an external source. I realize the fact that this is contrary to all teaching and that I may be branded a medical heretic, and given no mention in our great medical journals, but are you satisfied with the bacteriological data given on pneumonia, influenza and many other diseases as well, as the lack of explanation as to how the various epidemics get started? Nothing results without cause. Everything scientific has a plausible explanation and is demonstrable, but there are many things in etiology of diseases that are not even explained, let alone demonstrated. May not Metchnikoff's phagocytic theory be erroneous as well as some of the other noted theories? I predict the day to soon come when it will be fully shown that in many of the essential points it is entirely wrong and we shall have a new and more scientific explanation for many diseases and conditions.

Why do some diseases occur almost never in the warm months while others practically never occur during the cold months? Why are some diseases found only in certain localities and never in others? How is the sudden onset of certain diseases explained? Why are some diseased conditions found in every corner of the world? Cancer and tuberculosis that have been microscopically demonstrated to be, almost beyond doubt, the same organism in a different stage of development, are found practically everywhere and under all different conditions and surroundings, affecting alike the rich and the poor. All people use drinking water and few if any of the waters used for drinking, unless made sterile, are free from protozoa, and through this medium these organisms gain access. A cancer body, the leucocyte and the protozoan resemble each other under the microscope. A cancer body shows acid fast properties under the stain, and if a protozoan is put under suitable conditions, in a very short time acid fast bodies are demonstrable and often typical tubercle bacilli can be shown.

May not the sudden onset of pneumonia be explained by the fact that these protozoa in the body have reached a certain stage in development when the whole circulatory system becomes flooded with the diplococcus of pneumonia in a very short space of time? This organism has been shown to develop in this manner from the protozoan and to flood the field at a certain stage with the typical diplococcus of this disease.

These points have been demonstrated to my satisfaction more than once, and while they may not be listened to now, yet they are

so simple that they are plausible and undoubtedly clear up some of the heretofore unexplained points.

Time forbids my entering into this subject in detail, and I wished in this short paper to give only the thought as it had come to me from observations following in the course of study of scarlatina and its varied sequella and complications.

In conclusion, I am led to wonder how long the Metchnikoff theory of phagocytosis will be held together and how soon it will be laid away with the many other exploded theories. If this wonderful, life-saving, petted and haloed scavenger, might not be a devil in disguise, a destroyer with whom we had not yet reckoned, with whom we are about to become acquainted. That instead of its hastening to a point of injury or infection as a scavenger or life saver, if it might not have stationed itself here from the fact that here it found suitable surroundings and conditions for its rapid development, and instead of its fighting for the body it might be aiding the invading enemy.

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THE DIETETIC TREATMENT OF CHRONIC INTERSTITIAL NEPHRITIS.

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PHILIP B. MATZ, M. D., Assistant Surgeon, National Military Home, Kansas.

Read before the Northeast Kansas Medical Society, Feb. 8, 1912.

The condition of chronic interstitial nephritis is one of the most prevalent of diseases, especially is it common in the aged. The 1910 report of the National Home for Disabled Volunteer Soldiers shows that out of a total of 12,798 patients treated in the hospital departments, 997 were diagnosed as chronic interstitial nephritis and of this number 184 died. It is interesting to note that 310 of the 997 cases were being treated at the National Soldiers' Home, Togus, Me. The reason for this is to be found in what Purdy says, namely, "that the cold moist climate of the New England and Middle States predisposes to contracted kidneys."

There are a great many conditions which may cause it, but I think that the principal etiological factor in the aged is to be found in an altered and deranged gastro-intestinal function, and faulty metabolism, due to indiscretion in diet. Repeated gastro-intestinal disturbances may be followed by the production of unnatural chemical products, and these may be irritating on the kidneys and bring about the condition under discussion.

Faults on the part of such organs as the liver, pancreas, adrenals, thyroid gland, or even the muscles, might, by malperformance of function, lead to chronic renal disease; one very often sees cases of diabetes mellitus complicated by chronic interstitial nephritis.

Voit says, that a man at work eight to ten hours a day should ingest 118 grams of protein in twenty-four hours; Rubner advises 127 grams, and Atwater 125 grams. These figures have provoked a great deal of discussion.

Chittenden and Mendel say, that the average individual partakes of too much protein, and that a needless strain is imposed upon the liver, kidneys and other organs concerned in the transformation and elimination of the end products of protein metabolism. They teach that the daily ingestion of fifty grams of protein and food having a value of 2,500 calories, is sufficient to keep an average individual in good health. More than that throws extra eliminative work on the kidneys. The end products of portein metabolism, such as urea, creatin, hippuric acid, and phosphates are very irritating on the excretory organs and gradually set up inflammatory conditions.

In the aged, chronic constipation is quite common; this means that a variable quantity of protein suffers decomposition; a mild toxaemia is therefore always present, with resulting deleterious effect on the kidneys.

So that, as a result of deranged functions of the organs concerned in metabolism, and the ingestion of too much food, toxic substances are formed and go into the blood stream; the kidney parenchyma depends upon the blood for nourishment, the latter instead of bringing nourishment brings substances which irritate and gradually cause inflammatory changes. The parenchyma being diseased, is now unable to take care of and eliminate the end products of protein metabolism. These substances are absorbed and cause the train of symptoms present in the disease under discussion.

The condition of chronic interstitial nephritis may be combated in two ways; first, by prophylactic measures, and secondly, symptomatically, by drugs and dieting.

It has been said that the ingestion of too much food, especially protein, is one of the principal etiological factors of the condition under discussion. Every means should be adopted to spare labor to the already diseased kidneys and to the healthy kidneys in time of stress as occurs in the course of fevers and in chronic diseases. The kidneys may be so near the point of breaking down,

that injudicious dieting may supply the necessary additional irritation to cause the break-down.

It seems to me that the diet in the aged should receive more attention than is paid it at present. The gastro-intestinal tract and the glandular organs concerned in metabolic function are physiologically, abnormal; digestion is below par; furthermore, the appetite in the aged quite often is abnormal; there is an ingestion of too much food with subsequent ill effect upon the organs of digestion and elimination. The food in the aged should be nourishing, easy of digestion, and should contain a minimum amount of protein.

The drug treatment of chronic interstitial nephritis consists in combating the symptoms as they arise and is transient and very unsatisfactory; in fact it is at times very harmful inasmuch as some of the conditions that arise in the course of the disease are compensatory in character and ought not to be disturbed.

Polyuria, which is one of the principal symptoms is nature's effort to get rid of the excess of fluid ingested; check the polyuria, and you will most likely cause an oedema. Another example of illogical symptomatic treatment of this disease is the attempt made to reduce the blood pressure whether it be high or low. Here we have a diseased kidney which is in a condition of fibrosis. It takes rather high pressure to force blood through such an organ. The high blood pressure ought not to receive any attention unless it be so great as to cause dangerous symptoms.

To my mind the most rational form of treatment of chronic interstitial nephritis is one directed at the cause of the condition, and we know it to be a fact that one of the principal causes is a dietetic one. Reduction of food ingestion and especially of protein intake should be the aim. Of course, this form of treatment is prophylactic and palliative rather than curative. The symptoms present can be eradicated and life prolonged for some time.

The results obtained at the National Military Home Hospital under this form of treatment have been most satisfactory; grave symptoms have cleared up after the patients were placed on a low protein diet, and the functional activity of the kidneys showed marked improvement as was evidenced by the results of quantitative estimations of total nitrogen and total quantity of urine voided.

I have in mind a case admitted to the hospital on September 11, 1911, patient was a miner, 64 years of age, came in with symptoms of dyspnoea, and marked oedema of feet and legs. The heart sounds were weak and rapid; blood pressure 200; weight

150.5 pounds. The urine examination showed the presence of albumin, hyaline and granular casts. Total quantity voided in 24 hours, 375 cc. Total urea 5.60 grams.

He was put on well regulated diets consisting of protein which ranged from 62 to 68.5 grams in 24 hours, and worth from 1975 to 2190 calories. The water ingestion was restricted to 3 tumblers in 24 hours. On September 18, 1911, the patient weighed 147 pounds, having lost 3.5 pounds in a week's time, he voided 1850 cc. of urine, total urea excreted was 16.65 grams, and there was a marked reduction in the oedema. On September 25th patient weighed 145.5 pounds, and on October 16, 1911, he weighed 142 pounds, having lost 8.5 pounds in a month's time. The grave uraemic symptoms disappeared and the dropsical condition was no longer present, the dyspnoea also left him.

How was this accomplished? Merely by allowing the kidneys to rest and recuperate. The food and fluid ingestion was lessened materially so that the functional activity of the kidneys was reduced to a minimum.

In treating a case of chronic interstitial nephritis enough food must be given to meet the demands of the body. The diet must not be harmful but palatable; and the patient should be able to tolerate it for months or years if necessary. Simple easily digested food should be the rule, and taken with regularity. Rich and highly seasoned foods should be avoided. Condiments are not to be used, sweets and desserts are to be eaten sparingly.

The diet must contain a moderate amount of protein, as the latter is very essential. Absence of it should cause gradual loss of weight and cachexia.. A certain proportion of water and inorganic salts are also necessary for the maintenance of life.

Milk—As was mentioned before the diet, in chronic interstitial nephritis must be moderate in amount, palatable, and tolerated for a long time if necessary, so that milk alone as the diet, is out of the question, inasmuch as large quantities would have to be ingested daily in order to obtain sufficient amount of protein and a necessary number of calories. This would throw extra work on the heart and the kidneys, besides the monotony of the diet would tend to loss of appetite and gastro-intestinal disturbance. A moderate amount during the day, however, is most desirable. A tumbler of milk contains 8 grams of protein and has a fuel value of 140 calories.

Meat—Some clinicians are opposed to a meat diet in chronic interstitial nephritis, while others advocate a moderate use of same, say once a day. There is no more harm in a moderate meat

ingestion than there is in the use of other foods provided the total intake per day is not too great. Lamb chops are excellent in the diet of the nephritic. The lean portion of the chop contains 8 grams of protein and is worth between 50 and 100 calories.

Alcohol—If possible a patient having a chronic kidney lesion should avoid the use of alcoholic drinks. Where the patient is old and feeble, however, with a dormant appetite, and where he has been in the habit of taking alcohol all his life, the moderate use of wine and whiskey should be allowed and even encouraged. Each gram of alcohol is worth seven calories so that the fuel value of the beverage given can be easily estimated if the alcoholic percentage and the quantity are known.

Tea and Coffee—These beverages have no fuel value and may be given to nephritics in moderate amounts.

Condiments—These substances like pepper, mustard, garlic and nutmeg have no fuel value as a food, and are not metabolized. They are eliminated by the kidneys and irritate these organs; they should therefore not be used in chronic interstitial nephritis.

Carbohydrates and Fats—In order to make up the caloric value necessary for an adult considerable carbohydrate and fat must be taken in addition to the protein. Butter, cream and oil may be ingested; they impose no work whatever on the kidneys and add fuel value to the diet. Cereals, bread, vegetables and fruit may be eaten; their protein constituent is low, but fuel value rather high. The fodder vegetables, like asparagus, string beans, cabbage, cauliflower, celery, lettuce and tomatoes, do not furnish any protein and have practically no fuel value; they may be ingested ad libitum.

The question of fluid indigestion in a case of chronic intestial nephritis is very important. How much water shall the patient be allowed? There are two views; H. Strauss advocates the giving of water freely, even in excessive amounts with the object of flushing out the tubules of the kidney. The other view, championed by Von Noorden limits the quantity of fluid, contending that one of the functions of the kidney is the elimination of water, and to ask a damaged kidney to increase its functional activity is to violate the principle of rest for a diseased organ. The latter view is upheld by the profession and is the more sound of the two.

Fluid ingestion may be best regulated by finding out the total quantity of urine the patient voids from day to day and allowing him to take about the same amount of liquid. Ingestion

of too much increases the oedema and dysponea and is very injurious to the already overworked kidney.

The question of salt ingestion in chronic interstitial nephritis has aroused a great deal of discussion and contention. There is a prevalent idea which is supported by clinical investigations and results that a salt free diet tends to decrease the oedema, while a diet including an excessive amount of sodium chloride, increases the oedema. The investigators who make this claim say that their results were obtained in some cases with failure in others.

Some observers claim that the diseased kidneys are unable to eliminate sodium chloride, and that an abnormal quantity of the latter accumulates in the tissues, the serum being retained there to keep it in solution thus keeping the dropsy. Others say that the retention of water and the dropsy are primary, and the sodium chloride is required to balance the osmotic pressure in the blood, hence its retention.

Sodium chloride is very necessary in the economy of the body and to give a patient a diet which is free from this salt is, I think, bad policy. It is a known fact that hydrochloric acid is formed from sodium chloride ingested. Stop the taking of salt for a long period and there will be a diminution of hydrochloric acid secretion, with subsequent impairment of gastric digestion and gradual anemia and cachexia.

Forster fed dogs and pigeons a diet in which sodium chloride was reduced, the animals soon died. It seems as if they died more quickly while on a diet poor in salt than if they had been entirely deprived of food. So that I do not think it good treatment to stop the ingestion of sodium chloride altogether. A reduction in the quantity usually taken would be the better plan.

The mode of treatment used at the National Military Home Hospital is as follows: the diagnosis of chronic interstitial nephritis having been made, the patient is weighed, and a twenty-four hour specimen of his urine is obtained and examined for total urea or total nitrogen, and for total quantity. His blood pressure is also ascertained. The amount of liquid the patient is allowed is regulated by the quantity of urine voided in twenty-four hours. He is placed on the following diets:

DIET NO. 1.

BREAKFAST.

	G Protein	Calories.
1 Pat butter	0	80
1 Egg	8	100
1 Cup coffee	0	0
4 Ounces cream	4	240
2 Teaspoonfuls sugar	0	50
2 Slices bread	8	230
8 Teaspoonfuls corn flakes	4	160
DINNER.		
3 Ounces beef	16	100
2 Slices bread	8	230
1 Pat butter	0	80
½ Pint soup	8	130
1 Glass milk	8	140
SUPPER.		
2 ⅔ Tablespoonfuls scrambled eggs	16	180
1 Cup coffee	0	0
2 Tablespoonfuls sugar	0	50
1 Ounce cream	1	60
1 Slice bread	4	115
1 Pat butter	0	80
Total	85 G.	20.25 Cal.

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DIET NO. 2.

BREAKFAST.

	G Protein	Calories
1 Large orange	0	100
1 Shredded wheat biscuit	4	100
2 Ounces cream 20%	2	120
1 Slice bacon ½ ounce	1.5	90
1 Potato (medium)	2	90
1 Cup coffee	0	0
2 Teaspoonfuls sugar	0	50
1 Pat butter	0	80
1 Slice bread	4	115
DINNER.		
1 Glass milk	8	140
½ Pint soup	8	130
4 Tablespoonfuls boiled rice	4	200
1 Slice bread	4	115
1 Pat butter	0	80
3 ⅓ Ounces bread or rice pudding	4	175
SUPPER.		
1 Slice bread	4	115
2 Eggs	16	200
1 Ounce cheese	8	120
1 Cup coffee	0	0
1 Teaspoonful sugar	0	25
1 Ounce cream	1	60
Total	70.5 G.	2105 Cal.

DIET NO. 3.

BREAKFAST.

	G Protein	Calories
1 Large orange	0	100
4 Tablespoonfuls cooked cereal	4	120
2 Ounces cream	2	120
2 Teaspoonfuls sugar	0	50
1 Egg	8	100
1 Pat butter	0	80
1 Cup coffee	0	0
1 Slice bread	4	115
DINNER.		
2 Slices bread	8	230
3 Slices bacon 1½ ounces	4.5	270
1 Potato (medium)	2	90
1 Pat butter	0	80
1 Glass milk	8	140
SUPPER.		
1 Slice bread	4	115
1 Large orange	0	100
1 Small cup custard	8	160
1 Pat butter	0	80
1 Glass milk	8	140
1 Egg	8	100
Total	68.5G.	2190 Cal.

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DIET NO. 4.

BREAKFAST.

	G Protein	Calories.
1 Egg	8	100
1 Cup coffee	0	0
2 Ounces cream	2	120
2 Teaspoonfuls sugar	0	50
1 Slice bread	4	115
1 Large orange	0	100
4 Tablespoonfuls cooked cereal	4	120
1 Pat butter	0	80
DINNER.		
2 Slices bread	8	230
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Tablespoonful sugar	0	25
2 Chops, or 3 ounces beef	16	100
1 Small cup custard	8	160
1 Pat butter	0	80
SUPPER.		
1 Slice bread	4	115
1 Large orange	0	100
4 Tablespoonfuls boiled rice	4	200
1 Pat butter	0	80
1 Glass milk	8	140
Total	67 G.	1975 Cal.

DIET NO. 5.

BREAKFAST.

	G. Protein	Calories.
1 Egg	8	100
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Teaspoonful sugar	0	25
1 Pat butter	0	80
1 Slice bread	4	115
1 Large orange	0	100
DINNER.		
1 Glass milk	8	140
½ Pint soup	8	130
1 Small cup custard	8	160
2 Slices bread	8	230
1 Pat butter	0	80
2 Boiled potatoes	4	360
SUPPER.		
1 Egg	8	100
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Teaspoonful sugar	0	25
1 Pat butter	0	80
1 Slice bread	4	115
1 Large Orange	0	100
Total	62 G.	2060 Cal.

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RESULTS.

The results obtained with low protein diets are very satisfactory. It seems as if the good effect is not only on the gastro-intestinal tract and on the kidneys, but also on the circulatory system. Patients have been admitted to the wards with dyspnoea, nausea, anorexia, and high blood pressure, and after a few weeks of treatment with well regulated diets have improved markedly. An increased elimination of urea and total nitrogen was always noted. Those nephritics with oedema, either occult, or manifest, as a complication improved rapidly as was evidenced by disappearance of eodema and loss of weight.

Weights of patients before being placed on low protein diets, and after having been on same, showing loss of weight following disappearance of oedema;

	Before being placed on diet.		After having been on diet.		
Name	Date	Weight, lbs.	Date	Weight, lbs.	Loss, lbs.
Curtis	Sept. 4, 1911	116	March 17, 1912	114	2
Thomas,	Sept. 4, 1911	150	Sept. 18, 1911	146	4
Kittle,	Sept. 11, 1911	123	March 10, 1912	120	3
Turner,	Sept. 12, 1911	150.5	March 17, 1912	119	31.5
Chase,	Oct. 23, 1911	164	Dec. 4, 1911	149	15

McClure,	Oct. 16, 1911	171.5	March 17, 1912	140	31.5
Lewis,	Dec. 1, 1911	205.5	Dec. 31, 1911	195	10.5
Barnes,	Jan. 20, 1912	149.5	March 17, 1912	132.5	17
Hantz,	Dec. 1, 1911	149	Jan. 14, 1912	121.25	27.75
Schultz,	Feb. 28, 1912	150	March 17, 1912	144	6.
Purdy,	Feb. 28, 1912	196	March 17, 1912	162	34
Delaney,	Jan. 6, 1912	154.5	Jan. 14, 1912	151.5	3
Purdy,	Feb. 28, 1912	196	March 17, 1912	162	34
Delaney,	Jan. 6, 1912	154.5	Jan. 14, 1912	151.5	3

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Acute Indigestion.—A valuable formula for acute indigestion in children not over ten years of age:

℞ Bismuth subnit..... ʒij.
Cerii oxalatis.....gr. xl.
Elix. pepsini..... ʒiv.
Mist. cretae..... ℥j.
Aquae cinnimomi.....q. s. ad ℥iij.

M. Sig.—Teaspoonful every three hours.—Medical Summary.

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When dealing with a sliding hernia don't attempt to separate the large bowel from the sac; this attachment carries the blood supply of the gut. Free the sac, not the intestine, and reduce with the bowel as much of the sac as is attached to it.—American Journal Surgery.

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Active hemorrhage from a gastric ulcer is rarely fatal; the weight of evidence indicates that it is better to operate after than during the bleeding. Active hemorrhage from a duodenal ulcer is often fatal; operate as soon as the diagnosis is made.—American Journal Surgery.

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The measles and scarlatina rashes in small-pox are usually prodromal and go away before the true eruption occurs, but measles and the true eruption are very similar to smallpox at exactly the proper stage, especially in selected cases.

Points to be remembered are that the temperature remains in measles while in smallpox it generally drops when the eruption appears. The catarrhal symptoms are absent or at least very mild in smallpox as are the typical Koplic's Spots.—Ward (South California Prac.)

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Genito-urinary surgeons are agreed that in bilateral renal tuberculosis the logical treatment is removal of the diseased organ with as much of the ureter as is possible.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS: J. E. SAWTELL, CHAS. S. HUFFMAN, O. P. DAVIS.

Subscription Rates: $2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft, Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. J. T. Axtell, Newton; 1st Vice-President Dr, H. G. Welsh Hutchinson; 2nd Vice-President, Dr. G. M. Gray, Kansas City; 3rd Vice-President, Dr. G. W. Anderson Beverley; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H, Munn, Topeka; Librarian, S. G Stewart, Topeka.

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EDITORIAL

It has been reported that "Professor Samuels" of Wichita, who has been treating cancer, consumption and many other chronic ailments by instilling "drops" (which the A. M. A., Journal says is composed of sugar and salt water) into the eye,is to leave the state and locate in Detroit, Michigan. We presume the "going" became a little too "heavy" in Kansas and that he at least, thinks there will be less antagonism in Michigan.

It is with copious tears (of joy) that we bid a fond farewell to the "Professor."

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After twenty-nine years of active service as chief of the Bureau of Chemistry in the Department of Agriculture, Dr. Harvey W. Wiley has resigned. He gave as his reasons the belief that he could be of more service in the pure food and drug law enforcement as a private citizen, than in an official capacity. The reason for this can be readily explained from the fact that he has been hampered in his work by his associates and his superior officer the head of the Department of Agriculture. It is too bad that Dr. Wiley has been forced to this action, and his resignation will be received with profound regret by every honest man, who is acquainted with any of the work done in Dr. Wiley's department.

An editorial in the Journal A. M. A., March 23, makes some statements which are well to the point and worth reprinting:

DR. WILEY RESIGNS.

Damned with faint praise from the nation's chief executive, hampered by a reactionary departmental chief who has long since outlived his usefulness, badgered by a pettifogging lawyer of the night-school variety who, as a representative of the vicious interests, was able to nullify or render abortive efforts made in the interest of public health, Dr. Wiley has given up the unequal fight and handed in his resignation. Thus retires from the government service one of the most useful officials this country has ever had. An implacable foe of fraud and deceit, Dr. Wiley has for years stood between a more or less helpless public and the vested interests that have developed to a science the business of adulterating foods and sophisticating drugs and in other ways threatened the public health. On every debatable question regarding the wholesomeness of food stuffs, Dr. Wileywas consistently on the side of the people; his superior officers have been just as persistently on the side of those who have made their millions by substituting cheap and often poisonous drugs for more expensive but wholesome foods. Assailed from without by some of the most powerful, vicious and corrupt of organizations, he was also antagonized from within by the political henchmen of the same organizations. To Dr. Wiley more than to any other one man, the public owes the Food and Drugs Act and to Dr. Wiley it also owes whatever of good has been accomplished by that act. It is to be hoped that his forced retirement will result in such an upheaval of public indignation that the forces of evil at present in control of the Department of Agriculture will be driven into political oblivion and the department filled by men who hold decency above dollars, probity above pelf and public health above private gain.

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The Branaman Remedy Company, who have waxed fat on the credulous Kansans' and numerous others with loss of hearing, have (Journal A. M. A., March 23, 1912), 'received a set-back from the United State Circuit Court which will in all probability put them out of business for some time to come. The following comment from the Journal A. M. A., is interesting:

THE BRANAMAN REMEDY COMPANY.

Fraud Order Sustained.

The Dr. Branaman Remedy Company, a mail-order medical fake of Kansas City, exploiting a "cure for deafness," against which a fraud order was issued by the Post-Office Department, has received a final knockout blow through a recent decision of the United States circuit court for the western district of Missouri. The company had applied for a preliminary injunction against the postmaster of Kansas City to restrain the enforcement of the fraud order. This was denied by the court. In The Journal, Nov. 26, 1910, p. 1908, the story of this concern, which is conducted by Dr. G. M. Branaman, its method of exploiting the public with a cure for deafness and the results of an investigation by the Post-Office Department, was given at some length. It was the old and familiar falsehood of the great specialist who promised his victims free treatment and special personal attention. The usual symptoms-blank was required to be filled out, the stereotyped letters and the ready-made diagnosis were sent the victim, but instead of receiving free treatment, he was required to remit a neat sum for the apparatus and the whole outfit for the treatment of his case. Fraudulent testimonials were furnished and the whole rigmarole of the faker and the quack was gone through with. After investigation by the post-office employees, who took the role of patients of the quack concern, the Postmaster General issued the fraud order. The court, in reviewing the case on the application for the preliminary injunction, taking into consideration

the evidence accumulated by the Post-Office Department and such defensive matter as was submitted by the Branaman Remedy Company, held that the evidence not only warranted the making of the fraud order by the Post-Office Department, but amply sustained it. Where a fraud order is issued, in the opinion of the court, the presumption is in favor of the legality of the action of the Postmaster-General, and a strong showing is necessary to warrant the granting of an injunction. The court further says that the only cases in which courts will disturb a fraud order made by the Postmaster-General are when it is tainted with fraud, absolutely without authority of law, clearly outside of the statute, or, perhaps, clearly, palpably and obviously wrong. In the application for the injunction the complainant in his bill in equity claimed that his business and that of the Branaman Company "is and always had been a lawful one." The court said, "What might otherwise be a legal business or profession may be so conducted as to render it a vehicle of fraud and deception and bring it within the purview of the statutes authorizing the Postmaster-General to refuse the use of the mails in furtherance of schemes to defraud."

An interesting feature of the complainant's bill of equity asking for the restraining order against the Kansas City Postmaster was the allegation that the action of the Postmaster-General was the result of a conspiracy involving the American Medical Association, the Jackson County (Mo.) Medical Association and a number of doctors of Kansas City, as well as the attorneys for the government and the United States post-office inspector. This seems to be becoming the favorite defense of the quack, the faker and the nostrum-vender, when they are brought to book for their fraudlent methods—claiming conspiracy with others on the part of the American Medical Association, the great "medical trust", which seeks to destroy a lot of innocent, but enterprising gentlemen who are only seeking to benefit the people and incidently to earn an honest dollar. It is gratifying to know that through this deep-laid conspiracy the Branaman Remedy Company has been put out of business for a time—at least, until Branaman turns up again with some similar scheme or with the same old fake under a new guise and name—and that the credulous public has thereby been saved probably thousands of dollars, much suffering and permanent injury.

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The Missouri state superintendent of insurance, has issued a ruling, prohibiting insurance companies from writing insurance indemnifying physicians against damages for mal-practice. (Journal of the Missouri State Medical Association.)

Where he gets his authority for such an act is beyond comprehension. If there is a law on the statute books which refuses to grant physicians the right to protect themselves from grafters and shyster lawyers., then Missouri has taken a step backward from progress. There can be no possible excuse for such a ruling or for the passage of such a law. Certainly, no one could accuse physicians of mis-treating patients or giving them insufficient care simply because they are protected from mal-practice damage suits. Nor can we see how the fact that insurance companies cannot settle a suit without the consent of the physician, should make any material difference to the state. The policy would be of little value to the holder if companies could settle damage suits for mal-practice which are mostly fakes, without the consent of the physician. This could be taken advantage of many times by insurance companies, who could settle "trumped

up" claims for much less than the attorneys fees and court costs of the case.

Again, there would spring up claim after claim without merit, filed in the hope that a settlement could be made for a few dollars.

One cannot help but wonder how legislators who are presumed to have at least ordinary intelligence, can pass laws of such a character. Perhaps under the theory that "might is right."

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The annual meeting of the Kansas Medical Society will take place in Hutchinson, May 1 and 2.

It is needless to say that your attendance is very much desired and a glance at the program will show you that if you do come you will be more than repaid for the trip. The meeting will occupy but two days, (Wednesday and Thursday), whereas, in the past it has been three, the last one being "get-away" day, there being but few members to hear the closing of the program.

With the election of officers on Thursday, and the annual banquet on Thursday night the attendance will undoubtedly be as large the second day as the first. The program is all that could be desired; many papers being of great interest to the profession at this time, for instance: Cerebro-Spinal Meningitis; Secondary Suppuration, following Appendical Abscess; Treatment of Cancer of the Cervix Uteri; The Prevention of Tuberculosis and many others. It seems that every paper on the program is of such interest that we cannot afford to miss hearing one of them. There will be nothing to interfere with the program in a social or business way.

An automobile ride has been planned for the ladies at 2 p. m., on Thursday.

The headquarters will be at the Hotel Bisonte. Registration will be at the place of meeting in the New Convention Hall, Corner Avenue A and Walnut Streets. Following is the program:

PROGRAM OF THE MEETING OF THE KANSAS MEDICAL SOCIETY.

HUTCHINSON, KANSAS, MAY 1 AND 2, 1912.

Call To Order. Dr. Clemons Klipple, President Reno County Medical Society, Hutchinson, Kansas.

Invocation. Rev. Clarence S. Sargent.

Address of Welcome. Prof. Geo. W. Winans.

Response on Behalf of the Kansas Medical Society. Dr. J. T. Axtell, President Kansas Medical Society.

Meetings will be held in the new Convention Hall, Corner Avenue A, East and Walnut Streets.

Thursday Afternoon 2 p. m., Automobile Ride and Visit for Doctor's Wives to Morton Salt Plant and Kansas State Industrial Reformity.

Banquet Thursday Evening, May 2nd, at 9. p m., Bisonte Hotel.

"The Rights of a Child", Dr. J. R. Scott, Newton.

"Treatment of Lobar Pneumonia," Dr. X. Olsen, Clay Center.

"Development of the Elbow Joint," Dr. W. C. Lathrop, Norton.

"Hydrophobia," Dr. C. F. Hoover, Saffordsville.

"Cerebro-Spinal Meningitis," Dr. J. M. Parrington, Emporia.

"Medical Education in Kansas," Dr. S. C. Emley, Kansas City.

Paper—Dr. A. J. Weaver, Concordia.

"Artificial Infant Feeding," Dr. J. T. Scott, St. John.

"Catching Cold," Dr. N. Hayes, Seneca.

"The Present Status of Our Knowledge of Exophthalmic Goitre," Dr. E. C. Bowers, Wichita

"Cholecystitis With or Without Stone," Dr. Thor Jager, Wichita.

"Renal Stone," Dr. Martin Hagan, Wichita.

"Why A Medical Society," Dr. O. P. Davis, Topeka.

"Cord Changes in Pernicious Anemia," Dr. Ralph Hertzler, Newton.

"Surgical Treatment of Hallux Valgus," Dr. Jno. L. Grove, Newton.

"The Medical Profession," Dr. C. C. Goddard, Leavenworth.

"The Leucocytes in the Aged," Drs. P. B. Matz and H. M. Beardall, Leavenworth.

Paper—Adolph Koerber, Russell,

"Secondary Suppuration, following Appendiceal Abscess," Dr. Arthur Bowles, Ellsworth.

"Some Consideration in the Diagnosis and Treatment of Diseases of the Middle Ear," Dr. E. N. Robertson, Clay Center.

"Is Cancer Contagious, With Report of Cases?" Dr. J. C. Kirby, Cedar Vale.

"Anti-Tuberculosis Fight, and Some Field Notes," Dr. J. J. Sippey, Belle Plains.

"Typhoid Fever and Its Treatment," with Report of One Case," Dr. Paul Christman, Parsons.

"Typhoid Vaccine," Dr. M. D. McGomas, Fall River.

Paper—Dr. H. W. Manning, Eureka.

Paper—Dr. G. W. Jones, Lawrence.

"Closer Supervision of Pregnancy," Dr. H. L. Chambers, Lawrence.

"Physiological and Pathological Conditions as Revealed by the Urethra Cystoscope," Dr. C. S. Evans, Hutchinson.

"The Treatment of Cancer of the Cervix Uteri," Dr. Geo. M. Gray, Kansas City, Kansas.

"Appendix, Gall-Bladder & Co., What is the Relation Between These?" Hugh Wilkinson, Kansas City.

"Some Experience as Health Officer," Dr. W. T. Grove, Eureka.

"Hemorrhoids," Dr. W. W. Yates, Topeka,.

"Asthenopia," Dr. D. E. Esterley, Topeka.

"Tabes Dorsalis," Dr. E. H. Martin, Clay Center.

"Tonsils and Adenoids," Dr. H. L. Scales, Hutchinson.

"Country Practice in the Southwest," Dr. G. E. Kendall, Englewood.

"Diagnosis and Treatment of Ringworm," Dr. Leon Matassarin, Lawrence.

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Dr. George W. Maser of Parsons, Kansas, one of the most widely known physicians of the state, died at his home March 26. The cause of his death has not been learned at this date. To all those whose good fortune it was to know Dr. Maser, he was a man of sterling integrity, forceful in character, capable as the best, and a gentleman in the very best sense of the word. He was well-known in the medical societies, he being a member and a regular attendant of the Labette County, the Southeast Kansas, the Kansas State and the American Medical Association. He was well-known among the ophthalmologists of the country, chiefly by his contributions on detached retina, he having been very successful with an operation for this condition. He was much loved by his fellow-townsmen, who speak of him in the highest terms. He leaves besides his wife, two sons; George L. and John H. and a daughter, Miss Pearl. The funeral services were held Friday March 29. To have lived the life of Dr. Maser, was to have lived the best. To have done the good to humanity that he did, was to have done the best. Withal to be a man as he was nothing could be a higher ambition. The following short history is taken from the Parsons Sun:

Dr. George W. Maser was born in West Wheeling, Ohio, just across the state line from Wheeling, W. Va., Feburary 12, 1856. He attended the St. Vincent academy until 15 years of age when he went on a farm with his father at Rock Hill, Ohio. Here he remained until 21 years of age when he commenced the study of medicine in Bellevue Medical College, New York, and graduated from that institution in February, 1881. December 20, of that year he was married to Miss Kate P. Wuth of Bellaire, Ohio, and came to Parsons, December 30, of the same year, his death rounding out 31 years of residence in this city, most of this time occupying the office which he left 24 days ago, never again to return to it.

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NOTES OF THE ANNUAL MEETING OF THE STATE SOCIETY AT HUTCHINSON.

The meeting will be a two-day session, May 1st and 2nd.

Headquarters will be at the Hotel Bisonte.

The committee on arrangements is composed of Drs. C. A. Mann, H. G. Welsh, H. J. Duvall and G. R. Gage, all of Hutchinson.

The entertainment committee has furnished a list of the hotels of Hutchinson, with the rates charged.

HOTEL.	RATES.
Bisonte Hotel, (Harvey House).	
Chalmers Hotel,	$2.00 per day and up.
Midland Hotel,	$2.00 per day and up.
Baldwin Hotel, (American Plan),	$1.50 per day and up.

There are also several smaller hotels and a number of good restaurants.

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Upon arrival in Hutchinson go at once to Convention Hall and register.

There will be no guests from out of the state on the program. Everyone will receive the same close attention and the discussions should be spirited as the articles are all of interest.

The annual banquet will be held at the Bisonte Hotel, and it is safe to say that it will be O. K. The cuisine of the Bisonte is all that one could wish.

EIGHTH ANNUAL CONFERENCE OF THE A. M. A. ON MEDICAL EDUCATION, MEDICAL LEGISLATION AND PUBLIC HEALTH.

DR. S. J. CRUMBINE.
Delegate Kansas Medical Society.

The Council on Medical Education and the Council on Health and Public Instruction held their annual conference at the Congress Hotel in Chicago, February 26-27. The writer was appointed by the President of the State Medical Society a representative for that body. Owing to a snow blockade, our train was delayed so that the first half day of the conference was missed.

Mr. Frederick G. Hallette, secretary of the Royal College of Physicians, London, addressed the conference on "The System of Examinations of the Conjoint Examining Board." The examination of medical students for the degree of M. D., is conducted in the teaching hospitals by actual work upon clinical material, thereby demonstrating their fitness in a practical manner for entering upon the practice of medicine. This includes not only the physical examination of the patient and carefully prepared history, but such laboratory work as the case in hand, would necessarily require for a proper and scientific diagnosis. The same principle is applied to all the various departments of the teaching hospital, so that the entire list of subjects upon which examinations are held are of an intensely practical nature, very little stress being placed upon the written examination.

Things not included in practical work are taken up in an oral way, and thus each student is required to demonstrate his ability and to make manifest his merit before the degree is conferred.

Probably the paper that aroused the most interesting discussion was the one read by Dr. Reuben Peterson, Professor of Obstetrics of the University of Michigan, on "The Relation of the Medical School to the Interne or Hospital Year." The orator recommended the adoption of the fifth or hospital year, as a requisite for completing medical education. It was recognized that if the medical schools of the country adopted this program, which was universally endorsed by all of those taking part in the discussion, that it would neccessitate co-operation on behalf of all the larger hospitals of the country, in order that all the graduated students be furnished the opportunity to take the hospital year. Logically this situation would require that hospitals should be standardized after the same manner that medical schools of late years have been standardized, and that only such hospitals as came

up to the standard would be selected as interne hospitals. It was argued that hospitals that would be thus included in the adopted standards, would, in effect, be endorsed by the medical profession and the medical colleges of the country, and such endorsement would be of such great value as to warrant the changes in hospital administration and added facilities and equipment that would be required of most hospitals before they would be accredited as teaching and interne hospitals. It was very definitely pointed out by most of the speakers that it did not depend so much upon the number of beds in the hospital as it did upon their facilities for instruction—the two most important and required items being an extensive and up-to-date library and modern and properly equipped laboratories. It was argued that these untrained students were not presumed to be placed in the hospitals for doing the drudgery of such institutions, but that they might have the opportunity for clinical study and investigation, while, at the same time, giving valuable service to the institution.

Dr. Murphy, President of the A. M. A., declared that too much time was given in all medical schools to the teaching of principles and not enough time to the application of those principles. He declared that if the course of medical instruction was to remain at four years that at least one year of that time should be given over entirely to the work contemplated in the interne or hospital year. Most of the speakers agreed that the adding of this year was very much more important than to add any more requirements to the entrance; that the two years' college entrance requirements, or even less, was sufficient; but that the great need of American medical education was actual hospital experience, which so few are permitted to have.

In a questionnaire sent out to a large number of hospitals throughout the United States, having a hundred beds, or over, it was found that forty per cent. as I remember it, were at present equipped and conducted in a manner that would probably comply with the standards of an interne hospital. It was pointed out that the best of the European schools have had this hospital year requirement for a considerable length of time, although the years' work is not under the strict supervision that the American plan contemplates.

The necessity for an out-patient service with the hospital was emphasized and it is generally believed, judging from the remarks made in the lobbies, that this movement, which was so heartily endorsed, and I believe permanently started on its way, will revolutionize the hospitals work, the same as the Carnegie founda-

tion reports on the medical schools of the country has revolutionized and standardized those institutions.

The following day was taken up with medical and public health legislation, the Chairman of the Conference being Dr. Henry B. Favill of Chicago. Dr. Favill's address as Chairman, well nigh created a riot in the proceedings, or, at least, called forth some very heated discussions. Dr. Favill indicated that the physicians of the country should not as a profession, put any special pressure upon medical legislation—that it was the business of the organized profession, meaning the A. M. A., to educate the people in matters of public health and public welfare, so that, naturally, the proper legislation would be enacted by reason of an educated public opinion. Well, the way the doctors jumped onto that proposition was beautiful to behold! They declared it would be nothing short of a crime to at this time abandon their fight for the creation of a national department of health; that it would be a tacit acknowledgment of defeat; that it would leave the impression that the charges made by the League for Medical Freedom, were true, and that public health legislation would be set back half a century if we were to passively await the gladsome day when all the people would be educated to such a high standard as to take up active interest in public health legislation.

It is unnecessary to add that a resolution was offered strongly endorsing the action that the Association has hitherto taken in the matter of public health legislation, and re-affirming the demand that Senate Bill No. 1 should be passed.

After the Chairman's address the Committee on Resolutions and other committees were appointed, and the writer happened to be appointed on the committee on resolutions and had, therefore, the opportunity and the pleasure of voting for the resolution upholding the Association in its battle to protect the rights of the people, and demand legislation on matters of public health.

Dr. Wilbur's paper on Vital Statistics in the United States gave credit to Kansas as having a new vital statistics law which would ultimately admit her into the registration area.

The paper on the Essentials of State Legislation on Foods and Drugs by Prof. E. F. Ladd, commissioner of North Dakota, was frequently interrupted with generous and hearty applause. Among other things, Prof. Ladd advocated the creation by the Federal Government, or by each state, of a commission to which should be referred all formulas of patent medicines or other advertised nostrums, and that a license be required from the commission before such medicines would be permitted to be manufactured and sold.

The subjects of Railway Sanitation, Federal Inspection of Dairy Products and State and Municipal Health Officers, were ably discussed by specialists along those lines. Taken all together, the Conference was most instructive, illuminating and helpful.

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SOCIETY NOTES.

Following is the program of the Harvey County Medical Society for April.

"THE EYE."

"Relations of Iritis to Constitutional Diseases," Dr. S. S. Haury. Discussion, Dr. A. E. Smolt.

"Technique of Minor Surgery of the Eye," Dr. B. A. Countryman. Discussion Dr. J. L. Grove.

"Use and Abuse of Mydriatics," Dr. M. L. White. Discussion, Dr. S. S. Haury.

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At the Feburary meeting of the Barber County Medical Society, Dr. W. L. Welsh of Hazelton read a paper on Scarlet Fever, A Few Observations. Dr. O. A. Harmon read a paper on La Grippe, and Dr. J. J. Sippy, on Vital Statistics and the Care of Tuberculosis. The following officers were elected:

Dr. R. W. Coffee, Hardner, President; Dr. O. A. Harmon, Kiowa, vice-president; Dr. G. R. Waite, Kiowa, sec'y-treasurer; Dr. W. L. Welsh, delegate to the state society. Drs. Cloud, Stallard and Gilbert, censors.

After the meeting a banquet was held at which time there were fifty guests in attendance.

GEO. W. WAITE, Secretary.

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At the meeting of the Wyandotte County Medical Society held Tuesday, March 12, the following program was given:

SYMPOSIUM ON NEPHRITIS:

Anatomy, Physiology and Classification, Dr. Preston Sterrett.

Etiology and Pathology, Dr. H A. Nave.

Symptoms, Diagnosis and Treatment, Dr. Wm. F. Fairbanks.

The society is in better shape now than ever before. The membership has reached a total of 90, due largely to the efforts of the secretary, Dr. J. F. Hassig. This makes Wyandotte county the largest county society in the state.

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ANNUAL MEETING OF THE STATE SOCIETY AT HUTCHINSON, MAY 1--2.

The Sumner County Medical Society held a meeting at Wellington, April 4. The subject of the evening was "Education of the Public on Health Lines." The idea of the meeting was to have papers presented suitable for publication in the daily papers.

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THE NEMAHA COUNTY MEDICAL SOCIETY.

Centralia, Kans., Feb. 22, 1912.

The meeting was called to order by President Dr. W. G. Bouse.

Minutes of previous meeting read and approved.

Dr. C. R. Townsend read a paper on "Piles,". Discussed at length by all present. The author advocated the ligature as a curative measure.

Thorough dilatation of the sphincter, followed by the clamp and cautery, was the procedure of choice by most of the speakers.

The etiology and pathology were presented by Dr. S. H. Brown. The incipient condition he described as simply dilated veins, the result of partially obstructed portal circulation.

Dr. J. C. Maxson, from clinical notes presented the subject of puerperal eclampsia, and afterward closed the prolonged discussion by explaining the classic principles of treatment and his own particular and successful application of them. He emphasized the element of blood pressure as a cause of the convulsions. The address was concise and practical, founded on experience and a fundamental knowledge of the disease.

The secretary read a paper on "Blood Pressure," His thesis was that arterial hypertension should be regarded as a disease *per se*, till the cause of it—the underlying nature of the poison circulating in the blood—could be discovered.

That high pressure is a sufficient cause of arteritis, arterio sclerosis, all forms of Bright's disease, and many other incurable conditions, if the primary cause, usually discoverable, was not removed; that as a means of diagnosis the sphygmomanometer should be more used; that the immediate cause of puerperal convulsions was high pressure on the responsive nerve center; that the same were true of severe epileptic seizures, and that the prompt reduction of pressure would prevent the symptomatic convulsion.

Dr. Maxson reported a case of attempted suicide by swallowing a half ounce of carbolic acid, and the successful treatment with sulphate of magnesia, and repeated washings of the stomach with 25% solution of alcohol by means of the stomach tube-syphon.

The following resolutions were unanimously adopted:

First, All good physicians know that the advancement of Medical Science means the increased welfare of all of the people,

and of all governments, municipal, state and national; that the first essential of a good physician is high class citizenship, duly sensible of the heavy responsibility resting upon him, as an educated conservator of the morality, health and happiness of the people, and the sacred obligation to assume all such duties as will enable him to best serve the people, both in his professional and civic capacities; therefore,

Resolved, By the Nemaha County Medical Society of Kansas, in regular session assembled, That we endorse the candidacy of our honored member and officer of the Kansas Medical Society, Dr. Charles S. Huffman, for the office of Governor and that we pledge to him our loyal support regardless of political affiliations; all for the common good of Kansas.

(By Dr. J. H. BROWN.)

Second: Well knowing that there is a numerous nation-wide army of patent medicine grafters and impure food fiends, known as the League for Medical Freedom, who have duped into affiliation with them in their crusade of moral and commercial corruption other sectarian forces of medical practice, and the many cults of healing, and who are working together, have corrupted to a dangerous extent, the pulpit and the press; the state and national legislature, in their efforts to nullify the beneficence of the Pure Food and Drugs Act, who are hostile to all the blessings that state medicine has brought to the people, and would forbid all further efforts in that direction, therefore be it

Resolved, That we urge upon Congress the enactment of The Owen Bill, to create and maintain a Department of Health, to promote and protect the health of the people collectively and individually; and that we, as citizens, each write to our representatives and senators in Congress, requesting them to support the Owen Bill.

Third: Recognizing our efficient state Board of Health as a model for the country; that in common with our higher institution of learning, it returns many times ten-fold value to the state for every dollar it expends; that its members are faithfully and arduously performing a work of love and devotion for all the people, especially the unfortunate, an impressive example to all of us of professional and civic righteousness, therefore be it

Resolved, That we urge upon the legislature of Kansas, the high duty of generous appropriations to further its beneficient work; that we pledge ourselves to uphold, and work in harmony with it; and that we commend to the honor, respect and affection of the people its worthy and able secretary, Dr. S. J.

Crumbine, the honored Dean of our University Medical School.

Appreciating the substantial courtesy of its Centralia brethern, who made possible the interest and success of the meeting, the society adjourned at 6 p. m. to meet in Corning, March 21.

DR. W. G. BOUSE. President. N. HAYES. Secretary.

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NEWS NOTES

ANNUAL MEETING AT HUTCHINSON, MAY 1-2. WILL YOU BE THERE?

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Dr. T. D. Blasdell of Garnett, who has been in partnership the past five years with his brother, Dr. G. A. Blasdell, has located in the New Commercial Building, Parsons, Kansas, where he wiil limit his practice to diseases of the eye, ear, nose and throat.

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Dr. J. E. Hawley, Mayor of Burr, Oak Kansas, and Miss Rella M. Lambert, also of Burr Oak, were recently united in marriage.

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Born. Clinton Robert Lytle, to Dr. and Mrs. C. R. Lytle, Durham, Kansas, March 15, 1912.

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International Congress on Hygiene an Demography.—This congress will hold its fifteenth annual meeting in Washington, D. C., from September 23 to 28, 1912. President Taft is honorary president of the congress, Dr. Henry Walcott is president, and Dr. John S. Fulton is secretary-general. In connection with the congress, and in buildings especially erected for the purpose in Potomac Park, there will be an exhibit on public health in charge of Dr. Joseph W. Schereschewsky, of the United States Public Health and Marine Hospital service. This exhibit will open early in September and will continue until after the congress.

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The Methodist Episcopal Church is building a splendid hospital in Kansas City, Kansas. It is to take the place of the old one and is named Bethany Methodist Hospital.

Five and a half acres of very high, sightly ground in the very heart of the city has been purchased and a five story structure consisting of a main building 156 feet by 60 and a Nurses Home 40 feet by 50.

It will accommodate two hundred beds. Has three general

and one eye and ear operating rooms. Several rooms, such as "Recovery," "Delivery," "Baby Room," "Sterilizing," "Anesthetizing," and others, that bear a vital relation to operations. The first floor of the main building is largely devoted to administration, the second, third and fourth to patients exclusively. The furnace room and laundry, occupy the basement and first story respectively of the annex, and the other four stories are the Nurses Home.

The City is making a nine acre park in front of the hospital site. When finished, this Hospital will be one of the choicest and best equipped in Greater Kansas City. The enterprise is being largely financed by the sale of rooms. J. A. Motter is the superintendent and Elizabeth J. Eason, superintendent of Nurses.

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REVEIWS.

Foreign Body in Bronchus.—E. C. Todd, Minneapolis, (Journal A. M. A., March 9), reports a case of bronchoscopy with removal of a brass thumb-tack with two sharp, crooked points. Tracheotomy had to be performed before the operation could be completed, but improvement occurred at once on removal of the foreign body. It is probable, he says, that the foreign body may have been lodged for a time in the larynx or at least, have produced sufficient trauma there, to account for the very noisy breathing of the patient and the necessity of tracheotomy. It also shows, Todd says, the advantages of an x-ray picture covering the whole respiratory region, which was unfortunately not obtained in this case, though the general result was good.

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Cerebrospinal Meningitis.—The recent discovery of the fact that the natural habitat of the organism of cerebrospinal meningitis is in the nose and throat is considered by H. T. King, New Orleans (Journal A. M. A., Feb. 10), to be the most important contribution to our knowledge of the prophylaxis of the disease. With this fact also should be considered the discovery that the disease is carried from individual to individual, often by healthy carriers. The theory of direct extension from the nose and throat to the brain is untenable. The blood-route must be the one followed. In many cases the organism has been found in the blood and it seems to have a special affinity for the meningeal tissues. There must, be however, some lowering of tissue resistance or increase of virulence of the organism, and the cause of this may, in some cases, be a trauma. The disease is undoubtedly trans-

mitted directly from individual to individual and the number of persons carrying the infection is much greater during an epidemic than the number of patients. King estimates that nearly one-fourth of all individuals of the infected locality may be carriers of the disease without apparently showing any serious symptoms. Only occasionally do they present signs of a nasal pharyngitis or slight meningococcal infection. There are some persons who probably carry the germs permanently and perpetuate the disease. Up to the present there has been no absolutely efficacious means of causing the disappearance of the germs in the carriers, but the rigid observance of certain precautions would limit the extent and severity of epidemics. The first essentials for this are: 1. The earnest co-operation between the people and the health authorities in enforcement of all necessary health regulations. 2. The detection and isolation of healthy germ carriers. 3. Efforts toward rendering them harmless. Thorough sanitary inspection is necessary and attention to soil pollution, especially in rural districts. Particular efforts should be made to destroy all germ-carrying parasites and vermin. Circulars of information should be distributed. School inspection should be thorough and popular lectures will also be useful. A carrier once recognized should be put under the care and observation of the health authorities and treatment directed toward disinfection of the nose and throat. All carriers should be inoculated with the anti-meningococcal serum. The results should be constantly tested bacteriologically and oral and nasal hygiene be made a routine, not only with them, but with others. Fomites, such as vessels, spoons, handkerchiefs, etc., which have become infected should be thoroughly sterilized or destroyed and special directions as to spitting, sneezing and coughing be given to all carriers of germs. By these means we may hope to minimize the effects of the disease when it occurs.

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Early Diagnosis of Gastric Ulcer.—Smith, in the American Journal of Obstetrics, insists that the diagnosis of chronic surgical lesions in the upper abdomen can be made with accuracy, in the great majority of instances, by the anamnesis alone. This differentiation can be strengthened frequently by the physical findings, and later receive confirmation from laboratory examinations. He further points out that the symptoms of diseases in the locality under consideration, as generally understood and as taught in the text books are often those of the terminal events or of complications. Of gastric ulcer, the author says it will be found that the symptoms have existed periodically for at least

months, or more often, years. At first only an immoderate meal provokes the stomach distress. Later the one hearty meal was followed by pain, while the others were not so attended. Still later all three meals provoke the distressing syndrome. The fact that stomach symptoms have existed for a long period should of itself suggest the possibility of ulcer. That these symptoms have recurred in periodic attacks emphasizes the probability of ulcer. This periodicity is the most striking feature in the history of ulcer. In these earlier attacks the patient has perfect ease after taking food lasting from one to two hours in gastric ulcer and from two to five hours in duodenal ulcer, which is followed by a sense of weight, fullness and oppression in the stomach, later ameliorated by sour ecutation and the expulsion of mouthfuls of sour vomitus. It would be more correct to speak of the pain as preceding and as being relieved by the meal. In duodenal ulcer the attacks are often in the night, awakening from sleep. Tenderness on pressure is, of course, found. In a subsequent time when the symptoms are really those of the complications the appetite becomes fickle and the patient denies himself food because of the distress occasioned. Hemorrhage sets in long after the diagnosis should have been established.—Medical Standard.

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Arteriosclerosis—Treatment of.—Dr. Beverly Robinson, of New York, states that the larger his experience and the more he watches cases of pronounced arteriosclerosis, especially in men and women past middle life, the less frequently does he prescribe either digitalis or the iodides. If a cardiac tonic or stimulant is required, strophanthus, caffeine, and nux vomica are preferable by far and are not liable, in small or moderate doses, to do positive injury. They require also judicious watching and suppression at times, but not to the same degree as digitalis. To lessen supertension, where it is clearly indicated by reason of headache, fainting attacks, pallor and general nervous irritability, sweet spirits of nitre in small or moderate doses, added to water, is the least injurious and most useful drug the author knows of, not excepting nitroglycerin and the nitrites. Supertension in arteries, like the physical changes upon which it depends and with which it is allied, is highly conservative and should not be combated by any unwise attempts to control or modify it. Important measures in the treatment are change of scene and occupation; fresh air, good diet; with limitation in the amount eaten daily; and avoidance of excess of meat, sweets, alcohol, sauces, fats, uncooked fruits, or vegetables; and abundance of water internally. Phy-

sical exertion should be moderate, the skin should be kept in good condition, and mild saline laxatives should be administered twice a week.—Journal of the New Jersey Medical Society.

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MISCELLANEOUS.

Do You Read Medical Journals.—This may on first thought seem an impertinent query. There are a great many physicians who do not read their current medical literature, and who are, incidentally, losers by not doing so. A traveling man recently remarked to the writer that he was often amazed when calling on physicians from day to day to find the stacks of medical journals on the office table with the covers still intact. Another traveling man said he not infrequently found the office waste basket teeming with unread journals. Is this the fault of doctors or of the journals to which they subscribe? We believe that it is mainly indifference on the part of the doctors. Many excuse their lack of interest in medical periodicals by asserting that they depend upon text-books and thus get their medical pabulum from a more authorative source. This sounds well, but do they always do it? We believe men who are too lazy to read the journals are likewise inclined to eschew a more ponderous volume. Even the writers of text-books are not infallible. Generally speaking, we know that wisdom and truth are bound up between their lids, yet not a few text-books are simply a revamp of old and well-worn ideas embellished by the author's point of view. Even the writers of books have been known to have a paucity of experience. And this is not to be construed toward the discouragement of the reading of books; too often our silent friends on the shelves have their leaves untarnished by acutal use. There may be rot in the pages and between the lines of the medical journals, but it has the advantage of being served up in small doses. Our best ideas and most recent discoveries usually find expression in the pages of the medical journals; the physician who ignores them is losing a golden opportunity. The journal can be carried anywhere so that literally he who runs may read. One medical man states that he always has a journal in his obstetric bag or overcoat pocket. Such an individual is seldom lacking in medical lore, and he usually has it; as it were, at his very finger tips. The physician who peruses a dozen medical journals for ten years can not otherwise than be the possessor of a vast amount of medical lore. Another thing, most of the articles contained in the medical magazines are of a practical trend and contain suggestions that

Geo. M. Gray

PRESIDENT KANSAS MEDICAL SOCIETY, 1912-13.

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PRESIDENTS' ADDRESS.

DR. J. T. AXTELL, Newton, Kansas.

Doctors of The Kansas Medical Society: I am proud to meet with you today in our Forty-Sixth Annual Meeting. We have all of us reason to be proud of what the Medical Men have done, especially in the last few years. We have made it possible to prevent most of our contagious and infectious diseases. Until the discoveries of Pasteur were applied by Lister and others, Medicine could not be said to be on any scientific basis. We had accumulated a mass of knowledge by experience, while very little was known of the why. We knew the action of a large number of drugs and we employed them in an empirical manner. Pasteur showed us the cause of many of our infectious and contagious diseases and worked out the theory of immunity. Untold possibilities lie in acquired immunity.

It is not too much to predict that soon we may be using a serum or some remedy to make us immune to the dangers in an operating room. The medical profession has been a long time learning that many diseases are self limited. That in self limited diseases the results are not so different between the Indian Medicine Man, with his incantations and pow wows, that amused the relatives while Nature cured the patient and that of the physician with his drugs. In this same class of cases the osteopath and the Christian Scientist could at least do as well as the Medicine Man of the Indians—they could amuse the relatives. And the difference is not great enough for the public to see it. What we as physicians need today, is to be honest with the public. People do not always need drugs and when they do not, drugs should not be given. They always need advice that only a trained physician can give, and this is our stock in trade.

They need to know how to live and how to prevent disease. It is ridiculous to say that a child may as well be exposed to measles, whooping cough and other children's diseases! These diseases are preventable and should be prevented. And what does an Osteopath or a Christian Scientist know about the cause and prevention of disease? The Medical Men of today only are the ones who have learned these things, and the world wants to know them. Let us be honest with the people. Let us admit what we do not know. There is plenty that we only can do and our services will always be in demand as long as we have something that only ourselves have learned. Let us see to it that we have a true message to the world and our future standing is assured.

The President followed his address with a scientific paper which will appear in full in the June issue.—Ed.

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CHOLECYSTITIS, WITH AND WITHOUT STONES.

DR. THOR JAGER, Wichita, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

It is not the purpose of this paper to discuss cholecystitis or cholelithiasis in a thorough and complete manner, but rather to bring out some important features of the morbid condition in question and at the same time to point out some erroneous notions held regarding the importance and significance of certain symptoms in the clinical picture of the disease. It is not practical to treat of cholecystitis and cholelithiasis as independent and separate disease entities and the limitations of time, also prevents me from so doing.

In considering the cause of this disease, I shall only briefly mention the predisposing factors, of which age and sex are probably the most important. It is a well known fact that women are more commonly afflicted than men, and especially the women of the obese type. It is said that it rarely occurs in young people but mainly in individuals of, or past middle age. This is true, but from personal experience, I must state that it not so infrequently occurs in the young, as is commonly supposed. I have, in the last few years, seen quite a few young girls with cholecystitis and stones, one in a girl of sixteen. The role pregnancy and the wearing of corsets may play, we refrain from discussing, and at once consider the exciting factors of cholecystitis.

Cholecystitis is due to an infection of the gall bladder by certain bacteria, the most important being the colon bacillus.

This organism is normally found in the bile tracts, especially in the lower part of the common duct and becomes dangerous, only under certain conditions; for example, when an obstruction, complete or partial, to the flow of bile exists. If the latter is the case, the colon bacilli easily multiply and by their presence give rise to an inflammation of the gall-bladder and tracts, i. e., a cholecystitis and sometimes a cholangitis. This is an ascending infection, the bacteria originating in and ascending from the intestine, in contra-distinction to the typhoid infection of the gall-bladder, which is hematogenic in origin.

The invasion of the gall-bladder by the typhoid bacilli in the course of a typhoid fever, is a common occurrence, and does not necessarily lead to a cholecystitis. The typhoid organism can live in the gall-bladder for many years without producing any local disturbance. However, this condition is not harmless for bacilli are of course thrown out in the intestines from time to time, and may therefore, play an important role in distributing the disease by infecting the feces of the individual. The typhoid bacillus is such a very important cause of cholecystitis, that one should always in a suspected case of cholecystitis, inquire into the history of the patient to find out whether or not he has had typhoid fever at some time. Other organisms, especially the various strains of strepto and staphylococci play a certain role especially in the production of the purulent inflammations of the gall-bladder, the bacteria probably reaching the bile tract by the hematogenic route.

Pathologically, we distinguish the usual forms of inflammations found in any of the hollow organs of the digestive tract; we have, therefore, an acute so-called catarrhal inflammation; a suppurative, the so-called empyema of the gall-bladder; a gangrenous; a perforative and hemorrhagic type. Then we have a chronic cholecystitis which is to be looked upon as the result and following acute inflammations, especially the recurrent attacks of cholecystitis and is characterized by marked thickening of its walls due, to an increased amount of fibrous tissue, i. e., scar tissue. The gall-bladder may shrink as the scar tissue contracts and in some instances the lumen may become entirely obliterated.

The inflammatory processes are not always limited to the gall-bladder, but often extend to the surrounding peritoneum, giving rise to a peri-cholecystitis, acute or chronic. The so-called subphrenic abscess is not uncommonly caused by a primary gall-bladder disease. It may also extend to the smaller bile ducts, giving rise to a suppurative or non-suppurative cholangitis. If

obstruction of the common duct exists long, it may result in a so-called biliary cirrhosis. The infection may even reach the pancreas by way of the ducts, producing the various types of pancreatitis.

Until quite recently we have almost unreservedly accepted Naunyn's dictum, that the stones in the gall-bladder are always the result of a previous cholecystitis and in the majority of cases, this is true. The inflammatory changes in the gall-bladder and the partial or complete interference with the free flow of bile through the bile passages are certainly the most important factors in the production of stones. Of late, mainly through the work of Aschoff, Bacmeister, Gerard, Lichtwitz and others, it seems fairly well established that cholesterine can be precipitated from the sterile bile and thus we may have the formation of gall-stones in a non-inflammed gall-bladder. Such stones, however, are of the pure cholesterine type, and are certainly rather rare.

According to the chemical composition we distinguish following types of stones:

a. Cholesterine stones, are soft, waxy, yellow and almost transparent, and made up of cholesterine crystals and small amounts of organic and inorganic matter.

b. Cholesterine pigment stones, the usual type of stones encountered. As a rule there is more or less admixture of calcium salts. Color, size, and number variable. Cut sections of the stone frequently show a lamination.

c. Pure bile pigment stones are very rare. They are yellow, green, brown or black; of very light weight, and usually brittle.

d. Bile pigment calcium stones are dark, black, green, small, very hard and often mulberry-like.

e. Pure calcium stones are rare, and consist of carbonate of calcium, white, grey, very hard and heavy.

In regard to the number of stones, we may have from a single one to several thousand. The shape is variable, either round or oval, and if a number are present in the gall-bladder, the sides are frequently faceted.

Location and seat of formation is usually the gall bladder, but they undoubtedly may form in the ducts, even in the hepatic duct, and very rarely in the small bile ducts in the liver itself.

For reasons which I shall presently give a distinction in the symptomatology of cholecystitis and colelithiasis will not be observed in this paper. First of all, it may be well to state that the patient's gall-bladder and even ducts may contain a great num-

ber of gall-stones without producing any characteristic symptoms whatsoever.

The main characteristic symptom is the pain, the so-called gall-stone colic, which is usually sudden in its onset and consists of more or less severe and usually excruciating pains originating in the right hypochondrium and radiating towards the right shoulder, but not infrequently in other directions, even to the opposite side. These attacks of pain occur at intervals varying from several years to several days, and as a rule gradually growing more frequent. Contrary to many, and recent text book statements on the the subject, I wish to emphasize the fact that the gall-stone colic is not due to the movements of the stones in the gall-bladder or ducts. It is due to a contraction of the inflammed gall-bladder, the cholecystitis being the direct cause. This may seem a rash statement to many of you, but if you look into this subject carefully, you will see that this represents the truth.

There are a great number of cases on record where the patient has had the typical attacks of gall-stone colic, and operations have shown that the gall-bladder and ducts contain no stones. The stools have been examined for stones during and following the attack, so as to exclude the possibility of the stones having passed into the intestines. It is claimed by some, that the attacks in the absence of stones do not produce such severe pains, as when stones are present, but that is not true. I have seen cases when even one grain of morphine would not relieve the pain and still no stones were found at the subsequent operation, only a chronic inflammed gall-bladder. The colic then represents an acute exacerbation of a usually chronic cholecystitis and everything in the clinical picture goes to show that this is true, because we have the usual signs of inflammation present; fever, tenderness and leucocytosis. Then on the other hand, we frequently find gall-stones present at operation or at post mortem examination, which have been entirely latent and having given rise to no symptoms whatsoever, unless it be the original attack of cholecystitis many years ago, which caused the formation of the gall-stones. There are also many cases on record where stones of the size of a walnut have been found in the common duct without producing any pain during its passage there. I can recall at least two cases of chronic jaundice, which by its gradual onset and protracted course suggested obstruction of the common duct by tumor or chronic pancreatitis, but operation proved the presence of a large impacted stone in the bile papilla and yet these large stones had produced no

other signs than that of jaundice, because of the absence of an acute cholecystitis. To reason by analogy in comparing the biliary with the renal colic is false, as the anatomical structures are quite different especially, in reference to innervation.

In looking up the literature on the subject, I find that some of the greatest authorities on cholelithiasis, hold this view as to the unimportance of the stones in producing the colic. Naunyn in a recent publication, emphasizes this fact, which Kehr has long championed. Kehr has made as many gall-stone operations as any other man living, and it is to Naunyn, as you know, that we owe our modern conception of gall-stone disease. Sheldon holds that it is clinically, as well as experimentally proven, that the contractions of the inflammed gall-bladder is the sole cause of the colic attacks. Riedel, the well known authority on the subject, states that 90 per cent of the colics are due to cholecystitis alone. MacLaren and Kummel support him in this opinion. Fraenkel, Longuet, and Gignozzi believe that the attacks may sometimes be due to the perivesical adhesions. Solieri shares the view, also considering that the increased tension of the inflammed gall-bladder plays some role.

Thus we may consider it proved that the biliary colics are due to the contractions of the inflammed gall-bladder and that the stones play none or very little role in their production.

The second cardinal symptom is the jaundice which is present only in ten per cent of all cases and in a very variable degree. Formerly, we considered the presence of jaundice with the gall-stone colic to signify an obstruction of the common duct by stones, but we know now that this is not so. A very large stone in the common duct may produce no jaundice at all, because the duct may dilate sufficiently to allow the bile to pass by. And on the other hand, we find the jaundice present in many cases of biliary colic where no stones are found. It is then due to a complicating cholangitis affecting mainly the finer bile ducts. The chronic icterus in these cases is usually, but not always, due to the presence of a stone in a common duct, as a complicating pancreatitis may also produce it. The acute icterus is practically always due to a mild cholangitis according to Naunyn. It is not necessary for me to discuss the appearance of the stools and the findings in the urine in the cases with jaundice.

Vomiting is frequently present and frequently very severe. Fever is seldom absent, but does not necessarily become high, except in empyema of the gall-bladder or in the presence of some complication. Chills and sweats are observed mainly in the sup-

purative inflammation of the gall-bladder or ducts. Stone in the common duct sometimes give rise to the malaria symptom complex, chills, fever, and sweats, but in most cases it denotes cholangitis.

A palpable tumor is sometimes found in the region of the gall-bladder, and is then due to a hydrops, usually caused by an obstruction of the cystic duct by stones or inflammation. The enlargement of the gall-bladder is at times only apparent, as it may be mistaken for the so-called Riedel's lobe of the liver. The latter may also cover the gall-bladder in such a manner as to prevent one from eliciting the usual tenderness over the gall-bladder. Leucocytosis is frequently present in a mild degree, depending mainly, but not entirely ,upon the severity of the infection. The symptom complex described represents the typical clinical picture and is usually easily diagnosticated. But there are a good many atypical cases which present very mild manifestations, usually complaining of so-called dyspeptic symptoms consisting of a heavy, dull feeling in the region of the gall-bladder or stomach, eructation of gas and a feeling of fullness in the upper abdomen. One may sometimes elicit in these cases some tenderness in the gall-bladder region by deep pressure. It is always best to consider gall-bladder disease in the differential diagnosis of patients with such indefinite complaints, especially if they happen to be stout women in or past middle of life.

From the standpoint of differential diagnosis we have to consider practically all conditions giving rise to abdominal pain. First of all, appendicitis, which may be almost impossible to differentiate as the gall-bladder may sometimes be located very low down, even over MacBurney's point and on the other hand, the appendix may be located very high up, giving rise to the so-called high appendicitis. The clinical history may help one to distinguish these two conditions, and of course the presence of jaundice is a most important differentiating sign. Then rectal and vaginal examinations are helpful.

Next in importance are gastric and duodenal ulcers, which may simulate it perfectly. According to my experience it is the duodenal ulcer that is most difficult to differentiate, as it gives rise to periodically recurring attacks of pain in the upper abdomen. As a rule, we can learn from the history that unlike the biliary colic attacks, these attacks may last for several weeks at a time. Then we have the definite relationship of the pain to the meals in the ulcer cases and to the character of the food ingested, especially characteristic is the so-called night pain of duodenal ulcer.

The presence of blood in faeces or in vomited matter is of course very important. Hyperchlorhydria is a very poor differential sign, as it occurs almost as frequently in cholecystitis as in the ulcers where it is not infrequently absent.

Ileus sometimes must be differentiated, and as a rule, it offers no great difficulty. The persistent vomiting, meteorism, constipation, faecal vomiting, the clinical history and palpatory findings are usually sufficient. Acute pancreatitis with its sudden onset, pain, swelling and tenderness in the epigastrium, collapse, etc., may at times be confused with cholecystitis. Subphrenic abscess is differentiated by clinical history as to its cause and by the more or less characteristic physical findings. The so-called Dietle's crisis may simulate the biliary colic, but if you consider its rareness and that floating kidney is indeed uncommon in the type of individuals who are most liable to suffer from cholecystitis we will have no difficulty. In my experience that is the favorite diagnosis with many physicians and it is diagnosticated entirely too frequently. The floating kidney seldom produces symptoms until the physician calls the patient's attention to its presence. Renal colic, with the typical radiating pains and the location of tenderness and swelling, the urinary findings, and the result of X-ray examinations should be easy to differentiate.

Lead colic in painters, plumbers, and typesetters, may resemble gall-stone colic but is easily differentiated by examination of the gums and by the characteristic blood findings. Epigastric hernia, at times, may simulate the disease under discussion, but by bearing in mind the possibility of its occurrence and by the characteristic palpatory findings, it is usually recognized. The pelvic diseases of women like salpingitis, ovarian cyst with twisted pedicle, ectopic gestation, giving rise to attacks of pain, are readily differentiated by history and pelvic examination. Not infrequently we have seen patients with cardiac insufficiency diagnosticated gall-stone disease, in view of the presence of jaundice and the painful liver which of course is here due to a passive hyperemia.

Abdominal angina in a case I have seen was indeed very difficult to differentiate from a gall-stone colic, but a careful examination of the heart and blood vessels lead to correct diagnosis. At this place I wish to call your attention to the fact that the angina pectoris pain is not necessarily confined to the chest and arms but frequently radiates to the abdomen.

In cases associated with jaundice, we have to consider a number of conditions. The so-called catarrhal jaundice with vomiting, slight fever, and possibly some hepatic tenderness, should

not give us great difficulty to differentiate as it usually occurs in young individuals and is very seldom associated with severe pain and is of short duration.

Compression of the common duct, usually originating in the head of the pancreas or in the first portion of the duodenum, produce jaundice and according to Courvoisier's law, are distinguished by a much enlarged gall-bladder, usually palpable, while stones in the common duct producing chronic jaundice are as a rule associated with a contracted gall-bladder.

In some of the acute infectious diseases we may have quite a marked jaundice. This especially is true in pneumonia and as pain may frequently occur and in many instances confined to the abdomen, it not infrequently happens that it may be mistaken for cholecystitis and for that matter, often with appendicitis. If one keeps this in mind, and carefully examines the lung of all patients before the operation, this grave mistake is usually avoided. It may seem strange to you that pernicious anemia has been mistaken for cholecystitis, but I have recently seen a case in which a surgeon wanted to operate on "for gall-stones", on account of the patient's lemon-yellow skin and indefinite abdominal pains. This mistake is not excusable and is due to carelessness or gross ingorance on the part of the physician. Then at last we have the so-called referred pains which I have called your attention to before, in discussing pneumonia. In the last year I have seen a case of thoracic aneurysm produce a compression of the spinal cord and as a result radiating pains in the region of the liver. This patient had been operated on by a Chicago surgeon for alleged gall-stones, which he did not have and of course he had the same pain after as before the operation. I have also seen one case of tumor of the spinal cord, which the surgeon had operated on, mistaking the radiating nerve root pains so characteristic of this condition for gall-stone colic. This is the less excusable as the patient at the time had other symptoms which should have called the surgeons attention to the correct diagnosis.

Pott's disease of the spine, as you know, often produces pain in the abdomen, when located in the dorsal vertebra, but a careful examination of the spinal column by inspection, palpation and X-ray and a possible motor and sensory disturbance differentiates it to the careful observer. During my service in some of the neurological clinics, I have seen not a few cases of tabes dorsalis with conspicuous laparotomy scars over appendix or gall-bladder, and in spite of the patient's statement that the surgeon had told him that he had removed a badly diseased appendix or drained a

diseased gall-bladder, I cannot help but feel that he had mistaken the "gastric crisis" of tabes for appendicitis or gall-bladder disease, especially as the operation did not end or change the attacks of pain. This mistake can easily be avoided with some care and with a rudimentary knowledge of nervous diseases.

At last, I would like to emphasize the necessity of being careful in accepting a patient's statement regarding jaundice. The layman's notion of jaundice is indeed very vague, and if the attending physician does not indorse his statement one must be skeptical. The slight jaundice visible mainly on the sclera of the eye is often confused with light jaundice even by good physicians as I have had occasion to see. They mistake the yellow subconjunctival fat layers which in some individuals are conspicuous, for mild jaundice.

Briefly, turning to the complications, we will first consider empyema of the gall-bladder which can hardly be regarded as a complication as it represents only a type of cholecystitis. The septic symptoms usually predominate in the picture of this condition. Perforation of the gall-bladder with subsequent local and general peritonitis is one of the most dreaded complications. Suppurating cholangitis is practically always fatal and when a patient with a history of biliary colics develops chills, high fever, and sweats, jaundice with swelling and tenderness of the liver, it should be suspected.

Chronic pancreatitis according to Kehr is not an uncommon complication of gall-stone disease, but I do not believe with him that it can be diagnosticated during operation by palpating the head of the pancreas, which he states is stony hard in this condition. Any one who has made a great number of postmortem examination knows how little value one can put on this sign alone, as one not infrequently finds a very hard pancreas when the microscopical examination shows this organ to be normal, contrary to expectations. Ileus from impacted gall-stones is indeed rare and as a rule, stones of such a size as to produce intestinal obstructions have reached the intestine by perforating the gall-bladder or ducts into the intestine.

Babcock states that chronic cholecystitis not infrequently produces chronic myocarditis. This I think is a very far-fetched conclusion, as both are common conditions usually occurring at the same time of life. It is my opinion that they are quite independent of each other, and if any relationship exists we would like to reverse the sequence.

Carcinoma of the gall-bladder is said to be the result of the

continuous irritation by gall-stones, but I cannot help but feel that in some instances the stones may be the result of the presence of the cancer as we have then the ideal requirements for their formation.

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RENAL STONES.

DR. MARTIN HAGAN, Wichita, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

Every kidney stone begins with a nucleus of some material, other than the crystallizable substances from which it is mainly made up. The nucleus may be composed of mucus cells, debris, bacteria as typhoid or colon bacilli, blood clot, or some substance actively introduced into the urinary tract.

We recognize two factors as playing an important part in the production of renal calculi. First, the presence of one or other urinary salt in relative abundance in the urine, and second, some irritation of the urinary tract or its lining epithelium leading to increased discharge of a mucinus material.

The greater amount of mucinus material in suspension in the urine, the more likely will the crystalline elements which would otherwise have remained in solution becoming precipitated in the colloid menstrum. Once the neucleus is formed it acts as an irritant, keeping up an inflammatory process with the production of mucus and the building on of whatever salt is in abundance in the urine.

The most common urinary salts producing renal stones are uric acid and urates, oxylate of lime, and the phosphates. I will not consider the more rare forms as cystin and xanthin in this paper.

Uric acid is chiefly formed from neucleo-proteids taken as food or the waste products from the patient's tissues as broken down leucocytes. The oxylates come mainly from vegetable food and the gristle of meat, while the phosphates are contained in food and drinking water.

Kidney stone is rarely if ever composed of one salt, but usually is a combination of different salts. It may start as uric acid crystals, then take on a coat of calcium oxylate and finally if the urine surrounding it should become alkaline it builds up with phosphates. Hyperacidity of the gastric juice favors the production of renal calculi, by allowing the salts of the food to more readily pass into the urine increasing its specific gravity. To render the

urine alkaline by giving alkalines for any length of time would only favor deposits of phosphates on an already existing nucleus.

Renal calculi occur with peculiar frequency in certain sections of the country, probably due to lime contained in food or drinking water, as the introduction of pure, soft drinking water, has caused the disappearance of the condition. It has been the opinion of medical men for ages past, that gout is a condition allied in some respects to renal lithiasis, and as there is a hereditary tendency in gout, so also with kidney stones. The puerperal state favors the formation of renal calculi. I have had two cases in my own practice, in which I believe the condition was aggravated if not caused by the puerperal state.

Stone in the kidney may produce a group of symptoms that is fairly characteristic and could hardly be mistaken for anything else. Again, it may produce such a variable clinical picture that the establishment of a positive diagnosis may be attended with the greatest difficulty or may even be impossible. There are cases in which calculi may be present in the kidney for a long time without causing any symptoms, although this is exceptional.

The variability of symptoms in kidney stones can be accounted for by the fact that stone in the kidney represents a variety of different conditions, that is, it may be large or small, smooth or irregular, it may be fixed or moveable, it may be in the kidney proper, pelvis or ureter. It may be in an aseptic field or be accompanied by infection, and there may be one stone or many. Thus it is plain that the symptoms will depend on the conditions present and the findings will vary in the same way.

Renal stone, should in all cases be diagnosed, unless it be latent, because it is a condition that we have many ways to investigate, and it is one in which time can be taken for investigation. Very different in cases of acute appendicitis, or acute intestinal obstruction, where if we are to be of most service, to our patient we must make the diagnosis in few hours. Richardson of Boston, has shown that many a patient has gone on the operating table and had his appendix removed for chronic appendicitis, when the real cause of his trouble was stone in the ureter.

The assumption of stone in the kidney is based on a careful consideration of the character of pain radiating to the bladder and genital organs, sensitiveness to pressure in the region of the kidney, along the ureter, and the frequent desire to urinate with decreased quantity of urine.

The urine usually shows deposits of salts of which the calculi are composed. Pus and epithelium may be present, but the one

constant finding in the urine in cases of kidney stones, is blood. At times it can be seen plainly, with the naked eye, and with the microscope, fresh or old blood corpuscles, never fail to be revealed, unless, as rarely happens, that the stone completely blocks the ureter so that no urine can pass and the urine from the other kidney may be perfectly normal.

It occasionally happens that both kidneys are blocked with calculi at the same time, or that when one is obstructed the other becomes closed through reflex spasm. Uretheral catheterization combined with functional examination of the kidneys enables us to differentiate renal colic from cholecystitis, appendicitis or intestinal obstruction.

It is sometimes possible with a wax tipped ureteral catheter to obtain scratches of the stone on the wax which is diagnostic of stone. The X-ray is one of the valuable aids in diagnosing kidney stones. It will show any of the harder stones such as calcium oxylate, in practically every case and not only show the stones, but show its position and the number present. It is claimed by good authorities that the X-ray will show stone if it is present, in at least 90 per cent of the cases. It is applicable to a vast majority of cases, is without pain or danger and even in cases where we are able to positively diagnose stone without the X-ray, the ray should be used to determine the position and number of stone.

Renal lithiasis only causes colic, when the stone is sufficiently small to engage in the ureter. A large stone which is fixed in the pelvis, may for a long time give rise to no symptoms. The chief symptom caused by large stones when they do give symptoms are pain and hematuria. The patient may complain constantly for years of a sensation of heaviness and pain in the lumbar region, which at times may be severe, and radiate to the testicle, the abdominal wall, the bladder, or the opposite kidney, and again he may not have pain for weeks or months at a time. Hematuria is always accompanied by some pain. The bleeding may be slight or severe, at times apparently passing pure blood. It never occurs during rest, but is readily brought on by running, straining or riding.

Renal colic is caused by incarceration of stone in the ureter, which hinders the flow of urine, also by contractions which the ureteral walls make in an endeavor to expel the urine from the pelvis of the kidney or the first portion of the ureter. The attack commences with sharp pain on one side in the lumbar region, after some time pain becomes more severe and extends to the flank. Marked retraction of testicle is seen from the first. The pain is

of stabbing character, radiating along the ureter to the penis, the urethera, the glands, perineum and rectum. The patients suffers the greatest agony and tries by every means to lessen the pain. The pulse is small, the face is pale and covered with sweat, the extremities are cold, nausea and vomiting are frequent, and the patient after much straining, passes a few drops of urine. The attack lasts six or eight hours, or longer: when the stone enters the bladder the pain is relieved. It may pass from the bladder at any time or may remain and form the nucleus of a bladder stone.

The most important part of medical treatment is prophylaxis, which should aim first, to prevent the precipitation of crystals from the urine. Second, when crystallization has occurred to prevent the conglomeration by removing them as rapidly as possible from the kidney. Third, to prevent the necessary binding substance being present. When stone has formed in the kidney that cannot pass through the ureter it is useless to attempt to remove it by medical treatment, as there is no known remedy that will dissolve it in spite of claims to the contrary. We frequently see cases of renal colic in which there is no stone in the kidney, but a small concretion of uric acid or other substance is passing through the ureter. Here is where we should accomplish most by preventing other such formations which might remain in the kidney and result in stone.

Prophylactic treatment necessitates that the nature of the stone forming material should be known and this can usually be made out by examination of the gravel passed or examination of the urine. Uric acid calculi occur in the hyperacid urine containing brick dust deposits, showing uric acid crystals. Oxylate of limestone also occurs in acid urine, which contains a precipitate showing many calcium oxylate crystals. The phosphatic calculi occur in alkaline urine that is cloudy, becomes more cloudy on addition of heat, but clears on adding acetic acid. In case of uric acid stones all meats should be forbidden which contain large amounts of cellular elements, as sweet-breads, thymus, brain, liver, kidney and the flesh of young animals. In some cases the process of metabolism is so faulty that even on a suitable diet, excess of uric acid is produced. Uric acid appears in the urine either as a soluble salt or as uric acid itself. On an excessive meat diet, the urine becomes hyperacid and uric acid as such constitutes 80 to 90 per cent of that found in the urine, the soluble salt being correspondingly decreased. When the acidity is reduced by vegetable diet there is a greater proportion of the soluble form, on a proper mixed diet the two forms of uric acid occur

in about equal amounts and the low acidity of the urine holds the uric acid in suspension. All articles of food which increase acidity of the urine should be avoided. The patient should drink freely of pure soft water, and if this disturbs the stomach, areated mineral water should be tried.

The oxylate of lime that frequently produces renal calculi, is chiefly derived from food, the major part coming from spinach, rhubarb, tomatoes, sorrel, onions, turnips, tea, cocoa and the gristle of meat. The salts of oxalic acid contained in food are in an insoluble form, but are set free by the hydrochloric acid of the gastric juice so that the most important prophylactic treatment for this type of stone is, first, to withhold articles of food that contain the salts of oxalic acid and second, to control hyperacidity.

Phosphatic calculi occur in alkaline urine either as a result of fixed alkaline taken as food, or ammoniacal decomposition in the urine. This can be overcome by restricting vegetable diet and giving mineral acids if it is due to the fixed alkali, or giving sodium benzoate salol or urotropin, if it is the result of ammoniacal decomposition. The same treatment applies when we have a stone in the kidney that we cannot hope to remove by medical treatment. For the pressure pain of stone in the kidney, Casper of Berlin states: that glycerine is the only drug that does any good outside of opiates. He has given as much as five ounces twice a week and has been well pleased with the results. It produces no ill-effects except occasionally a slight diaorrhea. Renal colic calls for active palliative treatment. Morphine combined with atropine hypodermically usually controls the pain, but frequently spasm of the ureter cannot be controlled by the use of morphine, without producing dangerous narcosis. Hot applications locally and hot baths are beneficial. Two or four drams of compound spirits of ether in ten times its volume of salt solution per rectum, acts as an anti-spasmodic. Yet in extreme cases inhalations of chloroform may be necessary to afford relief.

Anuria, unless it can be relieved by catherizing the ureter, necessitates immediate surgical intervention. Ureteral catheterization, however, should always be attempted, before operation is resorted to.

When we have to deal with stone in the kidney there is but one way we can hope for a cure, and that is by surgical means. This should be strongly recommended in every case and if it is not done, the best we can hope for is that it remain latent, but sooner or later it is very certain to produce complications. If relief from pain is not obtained in a reasonable length of time or excessive

hematuria or other complications are present operation, should not be delayed.

For the surgical treatment of stone in the kidney, three operations are practiced; namely, nephrolithotomy, where the kidney is freed incised, calculi removed and the wound sutured. This operation is applicable only in aseptic cases.

Nephrotomy, where the kidney is freed incised, calculi removed and the wound left open, packed with gauze, practiced where there is a suppurative process in connection with stone in the kidney. The wound suppurates and finally heals by granulation.

Nephrectomy, which is the removal of the kidney and its contents, and is applicable in cases where the kidney is destroyed, where a large pyonephrotic sac is present or where the remaining kidney tissue is highly inflammed.

Case 1.—Mrs. F. B., age 29, occupation, farmers wife; family history negative, personal history in 1906, three weeks after child birth developed mastitis, which was opened and drained. In 1908 had a premature birth at eight months, caused by placenta previa. Her third period of gestation occurred in 1910-1911, and it was during the latter months of this pregnancy that she began to have attacks of pain in the region of the right kidney. Pregnancy terminated at term in February 1911. In May, 1911, had a severe attack of renal colic on the right side. On physical examination I suspected stone in the right kidney, an X-ray picture proved that to be the case. Called Dr. Bowers in consultation, and owing to the age of her baby and the extreme hot weather, we advised palliative treatment for a few months. On September 5th, she had a severe attack of pain in the left kidney, followed by profuse hematuria. She was taken to the hospital and an X-ray examination made, which showed two large stones in the right kidney and a light shadow of a stone in the left kidney. On September 12th, Dr. Bowers operated, removing two stones from the right kidney, by splitting through the kidney substance. This wound closed in about four weeks. On October 17th, operated on the left kidney removing a dendritic stone, by opening into parynchema of kidney. This wound closed in about three weeks, and patient was discharged from the hospital on November 15th.

Case 2.—Mrs. E. L. G., age 30, occupation, house-keeper; family history negative, personal history: Ten years ago was in a Kansas City Hospital six months for stomach trouble, has had urinary symptoms since childhood. First attack of renal colic 12 years ago, has had occasional attacks ever since. Baby born in

1909, attacks worse during pregnancy. Anuria, which lasted 52 hours, accompanied one attack. Abortion at 3 months in October 1911, believe to be caused by attack of renal colic. I saw this patient December 5th, 1911, in a very severe attack of renal colic. I sent her to the hospital and took an X-ray picture, which showed stone in the ureter. Dr. Bowers operated on this patient, December 7th, 1911, removing small stones from the ureter, 2 inches below pelvis of the kidney. Closed wound with catgut leaving gauze drains down to ureter, after few days wound began to drain urine and continued to drain for about three months, finally wound closed and patient discharged from the hospital March 27, 1912.

Case 3.—Mr. B., age 64, occupation florist, family history negative, personal history: Has complained of pain in back and right side for 20 years, treated many years for lumbago. Operated on 12 years ago for floating kidney, with no relief. Re-operated on 8 years ago for floating kidney, but without relief. He has never had an attack of renal colic, but the urine at times shows blood and pus in marked quantity. In June 1911, an X-ray picture showed stone in the right kidney, symptoms have continued the same since.

Case 4.—Dr. B., age 33, occupation, veterinary surgeon; family history, negative, personal history: (Referred to me by Dr. J. D. Clark for X-ray picture, August, 1909,) Father died of chronic bright's disease. Was thrown from a horse 12 years ago, injuring left kidney, dates his trouble from that injury. Has had repeated attacks of renal colic, passes sand and small gravel at times, much blood in the urine. X-ray picture three years ago showed a number of stones in the kidney. An X-ray picture a few days ago showed similar condition, only more pronounced.

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"APPENDIX, GALL-BLADDER & COMPANY."
What Is Their Relation?

DR. HUGH WILKINSON, Kansas City, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

I do not know that this paper will divulge anything new or remarkable to its hearers. Perhaps it will to some of you or at least present a subject in a way some of you had not thought of. The more experience one has in the handling of these diseases, the more he is struck with the complexity of symptoms, the difficulty, and at times the impossibility of differentiating them, to say nothing of the many cases where both, regions are diseased with a con-

sequent increase in the complexity of the symptomatology. Just exactly what the relation is between the gall tracts and the verimform appendix, I am not prepared to tell you, and one reason for bringing up the subject, was to get some ideas from those whom I hope for a discussion of the subject.

The function of the appendix, is, of course, unknown and while some have the gall bladder's uses all down to their own satisfaction, those men who have seen and treated it the most, are the ones most averse to telling us what it was made for. We are well aware that it is a very blind pouch, holding about 1 ounce of bile, and the ease with which its drainage can be blocked, its proximity to the virulent and other cultures of the bowels are ready explanation for the frequency of infections within it, and these infections probably account for the concretions found there so often. The fact that there is normally 30-50 or more ounces of bile secreted each day, makes the idea of its being a reservoir look ridiculous. It certainly must have some important function in the economy because men who have removed gall-bladders by the hundred and have had the chance to open the abdomen in certain cases some time after a cholecystectomy had been done tell us that nature trys her best to make a new gall-bladder at the site of amputation of the old one by a dilatation of the channels there. A few years ago the Mayos removed 40% of the gall-bladders operated on. They have come to believe more in its importance, and less than 20% are being removed now. No such caution is taken when dealing with the appendix.

We can figure out no reason why the diseases of the bile tracts should cause any particular disturbance in the appendix but it is reasonable to at least suppose that inflammatory troubles in the gall ducts and bladder, might be indirectly attributable to appendix disease. In the first place the portal vein drains the intestines and dumps all of its drainage into the liver. It would not be hard for disease products from an appendix to find their way into the gall ducts by this route. A well demonstrated example of this happens in typhoid cases, complicated with typhoid cholecystitis. Even gall-stones have been demonstrated to have typhoid bacilli as a nucleus.

Another explanation: we know what a variety of disturbances in gastric and intestinal digestion may arise from an old chronically diseased appendix (to say nothing of the acute cases). What is to hinder these intestinal and gastric disturbances being reflected or extended to the bile factory and store houses? All of the pathogenic germs found in the bowels in the variety of con-

ditions mentioned, have been isolated from diseased gall-bladders.

The symptomatology of a typical attack of gall-stone colic is well known as is that of an attack of acute appendicitis. But the more of these cases I see the fewer typical ones I see. Many of them can be figured out to a fair certainty, while others seem like a guess and make an operation more or less exploratory. In doing a consulting or referred practice, a surgeon must weigh every bit of evidence with care, and carefully compare physician's and patient's story in arriving at a conclusion as to what is on the inside and what is to be done about it. Many of these cases are seen by the surgeon in the interval, when to him, the symptoms are indefinite at the time, while if he could have seen the patient in an acute attack there would have been no question. These patients require extreme scrutiny to insure fairness to them, the referring physician and the surgeon himself.

A distinguished surgeon has said: that in 80% of the cases where the stomach seems at fault, she is only the mouthpiece for some other organ which is the seat of disease." The stomach certainly does a lot of "tooting" for "appendix, gall-bladder & company" when they get sick. A large per cent of cases of chronic appendicitis and gall-bladder disease have taken all or several varieties of stomach prescriptions, before they reach a surgeon to whom they rightfully belong. In working out these puzzles within the abdomen we must not forget, however, the other intra-abdominal troubles, both organic and inorganic. But the main point I wish to advance is the difficulty and at times the impossibility of separating the gall-bladder from the appendix in a diagnosis. I can cite you cases which at one attack pointed definitely and plainly to a recurrent appendicitis of severe degree when a few months later they had an attack of gallstone colic plain and simple, followed by jaundice, clay-colored stools, distinct tenderness over the gall-bladder and dyspeptic symptoms. Operation verified all of this. Other cases look like gall-bladder attacks when operation reveals a very sick appendix and a gall-bladder merely inflamed and distended with a grumous dark colored bile, and no severe pathology. In these latter cases the appendix is commonly bound down behind or to the right of the cecum and extending upward.

One word about jaundice. Jaundice as a symptom of gall-stones has been handed down for ages immemorable. It is a small factor in the diagnosis of this disease. Probably the average taken from many clinics, would show jaundice in less than 20% of gall-stone cases. It is present many many times without stones.

To be sure an impacted choledochus stone or a cancer of the head of the pancreas would give us a persistent and increasing degree of jaundice. On the other hand, a common duct swelled with a catarrhal inflammation either simple and alone or resulting from an old or recent appendicitis would make the patient pretty yellow and persistently so at times. The ball-valve phenomenon shown by the late Christian Fenger while not common is well known and at times easily recognized.

WHAT IS THE MORAL TO ALL OF THIS?

In operating on an abdomen for gall-bladder or appendix trouble, either alone, or probably combined, we incise through the right rectus muscle with a hole large enough and so placed that it can be enlarged to treat both regions. We seldom leave an appendix, diseased or not, when operating on a gall-bladder, and we seldom take out an appendix without feeling of the gall-bladder. There are legitimate exceptions of course, chiefly when handling pus. By so doing, we feel that we are spared many times, the embarassment of a continuance of the stomach aches after operating on one organ without investigating the other.

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PATENT MEDICINES OR NOSTRUMS.

L. E. SAYRE, Professor of Pharmacy, University of Kansas.

It is a well-known physiological phenomenon among medical students that, during the course of their medical study of diseases and their symptoms, they are usually affected with the belief that they are themselves afflicted with the particular disease under consideration. For example, if they are studying the heart, they will have an unusual pounding of the cardiac muscle leading to the belief that some heart lesion is present. If they are studying the liver, they discover some hepatic disturbance leading to a jaundiced condition. If it be the lungs, then immediately the attention is called to the respiratory organs and the air passages, when a depressed or abnormal condition of these organs is suspected.

Those who have read Jerome K. Jerome's story entitled: "Three Men in a Boat", will recall that in the first chapter the writer confesses that through the study of medicine, especially that of diseases and their symptoms, he contracted in due and rapid succession' all the diseases known to medical science, with the exception of house-maids knee'.

The same principle of psychological influence is illustrated

in the reading of the newspaper advertisements of patent medicines. The adroit and skillful manipulator of words in ordinary advertising practice, can make a man believe that he has every disease there presented, and, in addition, that the nostrum advertiser can supply the exact specific for these diseases. Our actions are so much more influenced by suggestion than by reason, that these artistic manipulators of the advertising art can play their seductive tricks with the skill of one who is master of the key-board.

Since the enactment of the Food and Drugs Law and the administration of this law in the various states, the patent medicine and nostrum business has become a subject of scrutiny on the part of scientific men, and those who are interested in public welfare. Those who are studying the question carefully are surprised at the extravagent claims made on the labels and wrappers of these nostrums and the almost total lack of merit of the preparation thus advertised. Such medicinal preparations have been exploited in Kansas. One of these has been advertised to cure about thirty different diseases, from consumption to bright's disease, by dropping the medicinal liquid into the eye. This liquid when analyzed at the University Drug Laboratory was found to consist of a watery solution of salt and sugar. The foxy proprietor of this preparation knew that the dear public would, by suggestion, be influenced to have the various diseases enumerated and be led to believe the brazen statements made; that this alleged remedy (salt and sugar), was the one reliable remedy for the long list of diseases enumerated.

Another one of the so-called patent medicines, calculated to allure public patronage is known as Fruitola and Traxa. This compound is alleged to be a 'system cleanser, to remove gall stones and to positively cure all stomach trouble'. On analysis, this alleged wonderful remedy is found to contain ordinary olive oil as the principal medicinal substance.

It is unnecessary to enumerate the results of analyses of scores of these nostrums in the drug laboratory of the University of Kansas. Suffice to say they are composed of ordinary medicinal agents—for which absurdly extravagant claims are made. Says Dr. Simmons of the American Medical Association: "The claims in the advertisement of 'patent medicines' have become so absurdly extravagant that these advertisements are synonymous with mendacity'.

Judge McFarland of Pennsylvania, when called upon for a legal decision regarding a case involving the merits of a certain class of patent medicines, said in substance: 'They are methods

of prescribing for diseases at long range. Any intelligent, thought ful persons knows that many of the symptoms listed in patent medicine advertisements are caused by many disorders other than the diseases cited. For one to diagnose his own case is the height of folly, yet these advertisers advise the poor, deluded victim to pass upon subjects often baffling to the highest medical skill. The enormous business done by the proprietors of medicine and the serious menace which it is to the health and lives of the public requires us to scrutinize carefully the ground upon which these nostrums stand. And it has shown that they belong to the reprehensible class.

The history of the patent medicine and nostrum business will show that originally they claimed to be inventions or discoveries in therapeutics. In process of time these so-called discoveries were found to be compounds of well-known simple remedies. One who can put together rhubarb and senna or calomel and jalap is certainly no discoverer, but merely a mixer of well known remedial agents. It is true that if these were mixed without ordinary professional skill they might be a mere jumble of things, but the mixing of them with proper skill cannot claim for them an invention worthy of protection as a patent.

WHAT SHALL WE HAVE TO TAKE THE PLACE OF PATENT MEDICINES?

For minor ailments, every home should be provided with well known household remedies. With these it should be the duty of the family provider to become not only well acquainted, but with some careful attention to become intelligent in their use. This should be the duty of the mother, who is naturally, from her position, the nurse of the family. These household remedies should contain ingredients about which there should be no suggestion of secrecy nor be even seemingly protected by a so-called misnamed 'patents.' They should be composed of well recognized medicinal agents, about which the physician, or pharmacist, should be able and willing to furnish reliable and trustworthy information without remuneration. This information should be given freely as it is common property, contributed by pharmacists and physicians and published in standard medical works.

If physicians, pharmacists and the public would combine and co-operate with each other along indicated lines, it would not be long before the days of the nostrums fakirs would be numbered.

ACUTE OSTEO-MYELITIS—REPORT OF A CASE.

DR. JAMES E. OLDHAM, Wichita, Kansas.

Read before the Medical Association of the Southwest, Oct. 11, 1911.

In looking over the field of general work that claims the consideration of the surgeon, osteo-myelitis is one of the most important diseases which we are called upon to treat. It would seem to the writer that no condition is fuller of responsibility, perplexing thought, doubt and uncertainty than it is.

In the beginning of the trouble when a correct diagnosis is of such grave importance, the disease is often mistaken for rheumatism, for typhoid fever, or meningitis, or inflammation of the external parts.

The symptoms depending upon the virulence of the causal organisms and on the situation and extent of the disease.

In the majority of cases there is usually violent fever and great pain in the first part of the disease. Although the fever is not always extreme. In some cases the fever does not rise about 102 degrees in the early stage, but the pain is uniformly severe. The rule is that the fever soon loses its violence and lapses into a typhoid type, being characterized by a weak, rapid pulse, headache, dry tongue, thirst, delirium and stupor. The pain, however, continues severe until relief is secured. If the affected bone is superficial, there is swelling and tumefaction. If the bone is deep-seated, there is no apparent swelling. Any attempt to move the part causes excruciating pain. And when in the long bones, the patient complains of a sensation of the bone breaking, when an attempt is made to change the position of the part. In very young children it is almost accidental that one recognizes and locates the disease, especially when stupor is present.

In the gravely serious cases the course of the disease may be so rapid that death ensues within three or four days from a general septicemia, while in others the patient may linger on through a long period and ultimately die of pyemia, ulcerative endocarditis or exhaustion.

When the disease is near the epiphysis the neighboring joint becomes inflamed, tender and swollen, but not necessarily or frequently suppurative. However, when suppuration does occur in the joint the prognosis is extremely grave. There is no disease in which the prognosis so depends upon early, vigorous and efficient treatment. I am speaking of the acute, suppurative inflammation of bone and do not refer to the cause in which

the disease follows wound, compound fracture, etc., in which the infection extends upward along the medullary canal and beneath the periosteum. In such cases the condition is equally grave but the diagnosis is more easily and more certainly made.

As before stated, acute osteo-myelitis must be deferentiated from rheumatism, typhoid fever, meningitis and from local abscess in the superficial structures. In rheumatism, the symptoms are more general; a number of joints are affected and the condition of the patient is less grave. In the case of an abscess in the outside structures you would not expect so serious general condition and moving the part or jarring the limb would not elicit so severe pain as would be produced were the case one of osteo-myelitis. The diagnosis from typhoid fever only occurs in the very acute cases where the invasion is sudden and poisoning is rapid and where the patient cannot give an account of his symptoms. This is particularly true in very young children. In general, when the onset is sudden and the symptoms violent, we should suspect septicemia rather than a continued fever.

Carefully feeling over the long bones and moving them in all directions will usually settle the matter of diagnosis. The child will in almost all instances manifest pain if there is disease of the bone. Again, pressure in the length of the bone, or striking in an upward direction such as smartly tapping the heel or knee when the tibia or femur is affected. This however, is not always present and in my observation, the exception is when the trouble is in the upper part of the femur. I can assign no reason for its absence in this locality. It is merely with me a personal observation.

The pathology of the disease has been settled by the laboratory. The staphylococcus pyogenes aureus is the cause in the vast majority of cases; although any of the pus producing organisms may cause it. In this disease we find the gravest staphylococcus infection with which the surgeon has to deal, and in this instance, the staphylococcus outranks the streptococcus in activity and virulence. The treatment consists in early and free opening of the medullary canal and thoroughly cleansing the cavity. The incision should be made down to the bone and extending the full length of the affected part. If the periosteum is not destroyed it should be turned back and preserved. If the disease has been present many days the periosteum will have become affected and there will be no good secured by its preservation. My rule is that when it becomes granular and roughened, to make no attempt to preserve it. After cleansing the cavity, the parts should be

carefully mopped out with carbolic acid, or iodine and the cavity well packed with gauze, and if in an extremity the part should be supported by a splint. If the trouble is in a lower extremity the patient should be kept in bed until the cavity is filled and the wound closed. If, however, the upper extremity is involved it is not essential to confine the patient to bed and on the contrary, the general condition will be improved by exercise.

In the later stage of treatment, especially when the part affected is in proximity to a joint, massage and passive motion to muscles and joint must be given to prevent stiffness. There will be adhesions of tendons and there will be destruction of the synovial membrane. There will also be exudates. The prevention and removal of these conditions will only be accomplished by hot bathing, massage and passive motion. The general functions of the body must receive careful attention and such tonics as indicated given.

I have the following case to report.

On March 17, 1911, I was called by Dr. John J. Sippey of Belle Plain to see S. S. aged 12; male, a stout and apparently rugged boy; family history good. One week before I saw him, after rather violent exercise at play with other boys during the afternoon, he was taken sick at night; a severe chill followed by fever. Within a few hours he was attacked by excruciating pain in the hip and upper part of thigh. The temperature was high, running 103 to 104 degrees within first twenty-four hours. This subsided to 101 to 102 degrees. but there was no lessening of the pain and any attempt to move the limb could not be borne. The boy complaining of a sensation of breaking his thigh when any attempt was made to deduct, abduct or flex the thigh.

When I first saw him he was resting in an invalid chair and would not bear moving to a bed.

When first seen the temperature was 101, pulse 112. On deep pressure just beneath the great trochanter a marked tenderness was observed; also over inner part of lower end of upper third of the femur. Striking the heel when limb was extended did not elicit pain, likewise tapping or striking the knee did not cause pain. No swelling, no discoloration of surface.

My diagnosis was osteo-myelitis and an immediate operation advised. After consideration the parents agreed to this and on the morning of March 20th I performed the operation.

An incision beginning immediately below the great trochanter and extending to junction of upper and middle third of the thigh was made. The periosteum retracted and the medullar canal

opened with trephine at lower extremity of the incision, and a furrow cut with a De Vilbiss bone cutter, well up under the great trochanter, at which point the blood was very dark. I chiselled off the side of the furrow so that I could introduce a bone curette. On introducing the curette I broke into a pus cavity from which fully one-half ounee of pus escaped. I carefully cleansed the part and applied tr. iodine. Packed with gauze and placed a rubber drain in lower part of the cavity. We dressed the part in hot bichloride solution, and supported the limb with a plaster paris dressing.

He was able to be out of bed and on crutches May 15th.

There were no complications. The temperature became normal immediately and he suffered no pain after the operation. For about 4 weeks after getting up he used crutches in walking, at which time the wound had completely healed and he has been perfectly well since then.

The unusual feature to me in this case is in the location of the trouble. This is the first time that I have seen an osteo-myelitis in the upper end of the femur, except when it followed a trauma. The usual part of the femur for the development of osteo-myelitis is the lower end of the shaft near the epiphyseal juncture where the blood supply is poorest.

Since the occurrence of this case I have wondered if similar cases did not explain some of the irregular types of hip joint disease which we are called upon to treat. Cases which develop suddenly and in which there is a great destruction of bone about the head and neck and about the great trochanter.

It has occured to me that the natural course of the disease would be through the neck and not through the hard shell of the shaft.

In the case above reported I am certain that the cavity extended well into the neck of the bone. The curette by approximate measure extended two inches in the line of the neck of the bone. In a boy of patients size I think this would reach the head of the bone.

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If the administration of hexamethylenetetramine gives rise to irritation of the urinary system, combine it with benzoate of soda. In this combination the drug never produces irritation. -- American Journal of Dermatology.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, J. E. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: $2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft, Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr, H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, E. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka

COUNCILLORS.—1st District, C. W. Reynolds, Holton; 2nd District, C. C. Goddard, Leavenworth; 3rd District, Hugh B Caffey, Pittsburg; 4th District, W. E. McVey, Topeka; 5th District, W. E. Currie, Sterling; 6th District, Arch D. Jones, Wichita; 7th District, J. E. Sawhill, Concordia; 8th District, O. D. Walker, Salina; 9th District, C. S. Kenney, Norton; 10th District, E. J. Beckner, Seldon; 11th District, J. A. Dillon, Larned; 12th District, W. F. Fee, Meade.

EDITORIAL

If you fail to receive the Journal after this issue and have paid your dues for 1912, please notify the editor at once. If you have not paid your dues then pay up, as the Journal will not return until the dues are paid.

——o——

The membership of our society is now 1250 paid up. Now it will not take much effort to increase the number to 1500, where it belongs. If your interest in the society's welfare is sufficient you will urge every eligible physician in your county to join. Explain to him the advantages of being a member. First, the cooperation of the other members; second, the protection from malpractice suits; third, being able to keep in touch with the medical progress in the state, and last being eligible to join the A. M. A., the most wonderful medical society in the world.

——o——

OUR PRESIDENT.

George Morris Gray was born in Waukegan, Illinois, March 4th, 1856.

His father Rasselas M. Gray was a native of Rhode Island and his mother Susan Dowst Gray, was born in Massachusetts. The family moved to Quindaro, Kansas in 1858.

His early education was obtained in the public schools of

Wyandotte, County. He began the study of medicine under the preceptorship of Dr. E. W. Schauffler in Kansas City, Mo. Graduated from the College of Physicians and Surgeons of Kansas City, Mo., March, 1879. In the fall entered Bellview Hospital Medical College, from which he graduated in 1880. Returned to his home and began the practice of medicine in 1880. He has been a member of the Kansas State Medical Society since 1879, being one of the oldest members in the society.

He has been connected with St. Margarets Hospital as surgeon since its beginning in 1887.

He was president of the Academy of Medicine of Kansas City, Mo., in 1910 and is now president of the Wyandotte County Medical Society.

As an example of the esteem in which he is held in Kansas City, Kansas, where he has spent his life, he was elected Mayor by a large majority on an independent ticket and it is needless to say that he made the best Mayor the city ever had.

The society is indeed fortunate in having as president a man so fit in honesty, integrity, ability and standing in the profession.

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The Annual meeting of the American Medical Association will be held at Atlantic City, June 4-7, 1912. This will be a fine trip for those who wish to combine a profitable medical meeting with a summer vacation. Atlantic City is one of the greatest summer resorts in the world and its close proximity to New York and Philadelphia make it an ideal meeting place.

Atlantic city always elaborately entertains the association and this year will be no exception.

Clinics will be held before and after the meeting at New York and Philadelphia. Kansas will be represented at the meeting by two Delegates, Drs. O. P. Davis and J. T. Axtell.

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The Owen Bill has been favorably reported on by the Senate committee on Public Health and is now before the Senate to be voted upon as Calender Bill No. 561. Now it is useless to suppose that Senators will vote for this bill unless urged to do so by their constituents and it is up to every physician of the country and every medical society to create sentiment for its passage. The bill as it now stands is bereft of any clause whatsoever that could possibly be construed as not being for the best interests of the general public. Now have you or your society done its fullest duty to help its passage? If not, then now is the time to GET BUSY. At the last meeting of the state society, Dr. J. J. Sippey introduced

a resolution, which was unanimously adopted, requesting our senators to use their influence toward the passage of the bill. The resolution was telegraphed the senators and it is to be hoped that it will bear fruit. Certainly it will if the profession of the state will lend a strong helping hand.

Since writing the above notice has come to this office that Senator Curtis has presented remonstrances against the Owen Bill from 24 cities of Kansas. To counteract this false sentiment which has been engendered by the so-called "medical league of freedom", every physician in the state should interest himself as well as the laity in support of the Owen Bill. Immediate action must be taken as the bill will be acted upon before June 10th, Petitions should be circulated and sent at once to Senators Curtis and Bristow.

Medical Societies should meet at once (a called meeting if necessary) and take immediate action, which should be telegraphed the senators. DO NOT DELAY.

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THE HUTCHINSON MEETING.

The annual meeting of the state society held at Hutchinson was a decided success. The physicians of Reno County deserve unstinted praise for their generous hospitality. They bent every effort toward a successful meeting and their efforts were crowned with success. That a meeting held in a city the size of Hutchinson could be so well handled is a decided credit to the profession of that locality. The hotel accomodations were ample and there was no confusion whatsoever in getting the guests comfortably located. Throughout the session a decided interest was exhibited in the papers presented, all receiving spirited discussion. The business matters of the society created a lively interest especially upon the subject of medical legislation, upon which it was generally agreed that the profession should take an active part if legislation of a harmful character was to be prevented.

The entertainments consisted of a musicale, an auto ride for the ladies and a banquet for all. The musicale was given Wednesday evening, by the Hutchinson band, assisted by vocalists and instrumentalists and was of very high class. The public had been invited to this meeting which was held in Convention Hall.

Drs. J. T. Axtell, S. S. Glasscock and C. C. Goddard addressed the audience on topics of interest. A friendly criticism might be offered the speakers for not talking more upon public health questions when the opportunity was at hand.

An auto ride was given the ladies on Thursday afternoon, the

itinerary including a visit to the reformatory and the Hutchinson salt works.

The banquet on Thursday evening was a success in every particular. It was held at the Bisonte and the service was most excellent. Our popular secretary was toastmaster and he acquitted himself with much glory. The following were the toasts:

Invocation, Dr. Clarence Sargent.

"The Future of the Kansas Medical Society," Dr. John T. Axtell.

"Looking Backward, "Dr. C. A. Maguire.

"Just Whatsoever—", Hon. A. C. Malloy.

"Opsonins," Dr. S. S. Glasscock.

"Sequale to Borderland," Dr. C. C. Goddard.

"A Voice from the Northwest," Dr. C. S. Kinney.

"Ex-Presidents," Dr. C. E. Bowers.

"Phi Beta Pi," Dr. M. T. Sudler.

"The Ladies," Dr. F. M. Daily.

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NOTES OF HUTCHINSON MEETING.

The Society accepted the invitation to hold the next annual meeting at Topeka, in 1913.

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The proceedings of the Council and House of Delegates will be published in full in the June issue.

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The total registered attendance was exactly two-hundred and fifty, which compares favorably with any of the previous meetings.

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Mention should be made of the masterful way in which the president, Dr. J. T. Axtell, presided. The program was long, yet every one was given a full hearing and the discussions were not curtailed.

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This year the meeting was confined to a two-day session, and it is a decided improvement. The last day of the session was the best attended, whereas heretofore, the last day has seen a very meagre attendance.

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The membership of the state society to date, is, according to the secretary, 1250. This is the largest membership the society has ever had. In all probability this will be increased to 14 or 1500 before the year is past.

The Journal will, commencing with this issue, exclude all drug advertising from its columns, not approved by the council on Pharmacy and Chemistry of the American Medical Association. The Council unanimously adopted a resolution to this effect at the last meeting. We can now hold up our heads and suffer no criticism on account of our advertising pages.

The scientific sessions were held in Convention Hall, an imposing structure, having a seating capacity of several thousand. The acoustic properties are fine, when the hall is filled, but for a small audience, great difficulty was experienced in hearing by those seated ten or twelve rows back. It is also very necessary that a carpet be laid in the aisles as the shuffling of feet adds to the confusion.

The twelve councillors of the society will hereafter act as associate editors. This action was taken at the Hutchinson meeting. That it will be a success goes without saying. They intend to collect the news items from the county secretaries of the councillor district over which they preside and also contribute to the editorial pages. We can expect a decided improvement in the Journal and a consequent increased interest in the happenings of the medical societies and medical men of Kansas.

President-elect, Dr. G. M. Gray, called a meeting of the councillors Thursday afternoon at the Bisonte Hotel, and the following committees were named:

Medical Defense.—W. E. McVey, Topeka; O. D. Walker, Salina; W. E. Currie, Meade.

Scientific Work.—C. S. Huffman, Columbus; O. D. Walker, Salina; M. T. Sudler, Lawrence.

Public Policy and Legislation.—W. F. Bowen, Topeka; J. F. Grace, Wichita; W. F. Sawhill, Concordia.

The following resolution presented to the council and House of delegates, by Dr. C. F. Menninger, was passed:

RESOLUTION FOR

Compulsory registration with Boards of Health of all specific diseases in private and public medical practice.

Whereas, Insanity and other mental defects, as well as other forms of degeneracy are increasing in America out of proportion to the population, and

Whereas, Veneral disease is also increasing in a menacing manner, therefore be it

Resolved, That, it is the sense of the Kansas Medical Society that there be compulsory registration with Boards of Health of all specific diseases, occurring in private and public medical practice. These reports shall be made confidential, reports to Boards of Health, to be open to inspection only to Health Officers and those authorized by law to solemnize the marriage vow.

The officers elected for the ensuing year are as follows:

G. M. Gray, Kansas City, Kansas, president.

Dr. H. G. Welsh, Hutchinson, vice-president.

Dr. Clemens Klippel, Hutchinson, vice president.

Dr. G. A. Blasdel, Garnett, vice-president.

L. H. Munn, Topeka, treasurer.

Dr. Charles S. Huffman, Columbus, secretary.

Dr. J. T. Axtell, Newton, delegate to the American Medical Association.

The following councillors were elected to fill vacancies, caused by expiration of terms:

First district, C. W. Reynolds, Holton; second district, C. C. Goddard, Leavenworth; seventh district, J. E. Sawhill, Concordia; eighth district, O. D. Walker, Salina; ninth district, C. S. Kenny, Norton; These are elected for a term of three years.

The secretary was elected last year for a term of three years.

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The second annual school for physicians and health officers will be held at the University of Kansas, Lawrence, June 10 to 15th, inclusive. It is entirely under the supervision of the State Board of Health and the School of Medicine of the University of Kansas. All practitioners and students of medicine are invited. The course is free. As will be seen, the clinic day will be held on Saturday from 11 a. m., to 6 p. m., at the Bell Memorial Hospital, Rosedale, Kansas. The meeting last year was a decided success and indications point to a much better meeting this year, both as to program and attendance. The progress made in the past few years in Public Health Service; namely the special training for physicians and health officers is assuming large proportions. That a great deal can be accomplished in this plan of education, there can be no doubt. In all probability this marks the beginning of what will eventually crystallize into a Post-Graduate course, especially designed for physicians and health officers, leading up to the degree of Doctor of Public Health.

Such a department has already been established in four of the largest universities in this country and Kansas ought not be in the rear of the procession. This all spells progress in large type. The program follows:

MONDAY, JUNE 10.

A. M.—Registration—Fraser Hall.

P. M.—Annual Meeting, State Association of Health Officers—Snow Hall.

8 P. M.—Annual Banquet Health Officers and Physicians, Eldridge Hotel.

TUESDAY, JUNE 11.

8:30 A. M. Opening Second Annual Summer School for Physicians and Health Officers—Snow Hall, Chancellor Strong.

9 to 11 A. M. Laboratory—Dr. T. H. Boughton, Professor of Pathology and Bacteriology, School of Medicine, University of Kansas. (Collection of samples, etc., Methods of examination. Preparation media.)

11 A. M. Lecture—Waterborne diseases—Epidemiology of Typhoid Fever, Methods of Control, etc. Allan J. McLaughlin, M. D., Past Assistant Surgeon, U. S. Public Health and Marine Hospital Service, Washington, D. C.

2 P. M. Lecture—Waterborne Diseases—Cholera, Dysentery, "Winter Diarrhoea", etc. Allan J. McLaughlin, M. D., Past Assistant Surgeon, U. S. Public Health and Marine Hospital Service, Washington, D. C.

3:30 to 5 P. M. Laboratory Exercise—Each student performing for himself the work of the morning demonstration. (Optional). Prof. Boughton.

5 to 6 P. M. Lecture—Water Supplies and Water Purification, Prof. Wm. C. Hoad, Engineer, State Board of Health.

8 P. M. Illustrated Lecture—Insect Carriers of Diseases, Prof. S. J. Hunter, Entomologist, University of Kansas.

WEDNESDAY, JUNE 12.

9 to 11 A. M. Laboratory—Prof. T. H. Boughton.

11 A. M. Lecture—Epidemic Cerebrospinal Meningitis, Dr. W. H. Frost, Past Assistant Surgeon, U. S. Public Health and Marine Hospital Service, Washington, D. C.

2 P. M. Lecture—Epidemic Anterior Poliomyelitis, Dr. W. H. Frost, Past Assistant Surgeon, U. S. Public Health and Marine Hospital Service, Washington, D. C.

3:30 P. M. Laboratory—Exercise—Each student perform-

ing for himself the work of the morning. (Optional). Prof. Boughton.

5 P. M. Demonstration—The Interpretation of Water Analysis, Prof. C. C. Young, Chemist, State Water Survey, University of Kansas.

8 P. M. Illustrated Lecture—Abnormalities. Prof. C. C. McClung, Professor of Zoology, University of Kansas.

THURSDAY, JUNE 13.

9 to 11 A. M. Laboratory—Prof. T. H. Boughton.

11 A. M. Lecture and Demonstration: The Principles of Ventilation in the Light of Recent Investigations. Dr. Thos. R. Crowder, Sanitarian, Pullman Co., Chicago, Ill.

2 P. M. The Principles of Public Sanitation. Dr. Thos. R. Crowder, Sanitarian, Pullman, Co., Chicago, Ill.

3:30 P. M. Laboratory Exercise—Each student performing for himself the work of the morning. (Optional). Prof. T. H. Boughton.

5 P. M. Lecture—Drug Adulteration and Drug Standards—Demonstration. Prof. L. E. Sayre, Dean of the School of Pharmacy, and Drug Analyst, State Board of Health, University of Kansas.

8 P. M. Lecture—The Social Factor in Disease. Prof. F. W. Blackmar, Dean of the Graduate School and Professor of Sociology and Economics, University of Kansas.

FRIDAY, JUNE 14.

9 to 11 A. M. Laboratory—Disinfectants. Prof. T. H. Boughton, M. D.,

11 A. M. Lecture and Demonstration—Food Adulteration.

2 P. M. Round Table—The Problems of the Physician and the Health Officer, conducted by Dr. S. J. Crumbine, Secretary State Board of Health.

3:30 P. M. Laboratory Demonstration—Disinfectants. Prof. T. H. Boughton, M. D.

5 P. M. Antitoxins, Serums and Vaccines. Prof. T. H. Boughton, M. D.

SATURDAY, JUNE 15.

Bell Memorial Hospital, Rosedale, Kansas.

11 A. M. Clinic in Surgical Wards. Doctors Sudler, Sutton and Hertzler.

2 to 4 P. M. Clinic in Medical and Obstetrical Wards. Doctors Murphy and Guffy.

4 to 6 P. M. Clinic in Eye, Ear, Nose and Throat. Doctors Sawtell, May, etc.

"KNOCK" A KANSAS ALMANAC.

Healers and Patent Medicine Men Don't Like Crumbine's Hints.

TOPEKA, APRIL 4.—The patent medicine manufacturers, faith healers, osteopaths and chiropractors are trying to stop the distribution of the Kansas Health Almanac among the people of Kansas.

A letter has been sent to every school teacher and to county and city superintendents by the League of Medical Freedom asking that the health almanac be thrown in the waste basket and that the pamphlet be not used as a textbook for school work in preventing diseases.

The patent medicine manufacturers have been sending out a letter of their own urging druggists and others not to distribute and to advise their patrons not to read the health almanac.

The almanac was issued by the state board of health as a part of its work in making Kansas people healthier and stopping the spread of preventable diseases. Among the health hints printed was this one:

Avoid patent medicines as you would a pestilence.

The patent medicine makers assert the state board is driving out the patent medicine business in Kansas, and they are trying to stop it by advising against the use of the health almanac.—K. C. Star.

The above is just a sample of the activity of the "League of Medical Freedom", This very excellent almanac of the State Board of Health edited by Dr. Crumbine must be doing a great deal of good or there would not be the howl from these patent medicine vendors that has come forth. They are certainly busy in Kansas and have plenty of currency to aid them.

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SOCIETY NOTES.

The annual meeting of the Oklahoma State Medical Association was held at Shawnee, May 7-9, 1912.

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The annual meeting of the Missouri State Medical Association was held at Sedalia, May 21-23, 1912.

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The Wyandotte County Medical Society will adjourn for the summer May 22. Meetings will begin again the first Tuesday in October.

Program of the Harvey County Medical Society for May, 1912:

"THE UTERINE APPENDAGES."

"Etiology and Pathology." Dr. R. H. Hertzler, Discussion Dr. R. L. McClymonds.

"Symptoms and Diagnosis." Dr. N. A. Seehorn. Discussion Dr. Max Miller.

"Surgical Treatment, Diseases of the Uterine Appendages." Dr. A. E. Hertzler. Discussion, Dr. R. S. Haury.

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The Nemaha county medical society met at 2 p. m., in the office of Dr. C. E. Tolle.

Minutes of previous meeting read and approved.

After routine business the following were elected to membership:

Drs. W. H. Henschele, Corning; S. M. Hibbord, Sabetha; R. B. Houston, Baileyville; J. R. Purdum, Wetmore; C. E. Tolle, Goff.

Adjourned to meet at Sabetha, May 23.

W. G. BOUSE, President. N. HAYES, Secretary.

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The Cloud county medical society met in regular session on the evening of April 18th, at Concordia with a majority of the doctors of the county present.

Dr. Chas. Stein of Glasco presented an interesting and practical paper entitled "Substitute Feeding of Infants, with special reference to some recent advancements."

Dr. W. F. Sawhill of Concordia read a paper on "Type of Disease" in which he compared the different manifestations of disease in this western country with the same conditions in the eastern states, speaking particularly of pneumonia, typhoid fever and rheumatism.

The next feature of the program was the giving of case reports. in which most of the physicians present took part.

Four new members were admitted to the society, Dr. A. G. Lacert, Concordia, Dr. Amy Belot, Aurora, and Dr. T. C. Kimble and Dr. B. P. Smith of Miltonvale.

E. N. ROBERTSON, Secretary.

P. S.—A resolution officially commending the candidacy of Dr. Chas. S. Huffman for governor of the state of Kansas was unanimously adopted.

MEETING OF THE SMITH COUNTY MEDICAL SOCIETY.

Smith Center, Kansas, April 18th, 1912.

Meeting called to order by Dr. Watts, vice-president, and the minutes of the last reading were read and approved and thereupon the following officers were elected for the year 1912:

Dr. Watts, president, Dr. Funk, vice-president; Dr. F. H. Relihan, secretary and treasurer; Dr. H. A. Dykes, was elected delegate to the state convention and Dr. Raymond Love, as alternate.

Board of Censors.—Dr. Stephenson, for three years; Dr. Morrison, for two years; Dr. D. W. Relihan, for one year.

The society endorsed the efforts of Dr. H. A. Dykes to rid the state of irregulars and quacks, and tendered him their support.

It was thereupon agreed that the society should in the future, meet every ninety days.

The following papers were thereupon read and discussed:

"The Physician Himself," Dr. Watts.

"Cerebrospinal Meningitis," Dr. Funk.

"Medical Organization," Dr. Kenney.

"Eclampsia," Dr. F. H. Relihan.

"Colles' Fracture," Dr. Bowen.

"Medical Defense," Dr. McVey.

The following doctors were present: Doctors Stephenson, H. A. Dykes, J. B. Dykes, W. T. Mays of Lebanon, Kansas; Dr. Watts of Womer; Dr. Love of Athol; Dr. Thompson of Harlan; Drs. D. W. Relihan, H. Morrison, C. C. Funk, F. H. Relihan of Smith Center; Dr. Tallman, of Gaylord; Dr. Golden of Kensington; Drs. Kenney, Cole and Lathrop of Norton; and Drs. Bowen and McVey of Topeka, Kansas.

This was, by far, the best meeting that this society has ever had.

F. H. RELIHAN, Secretary.

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The semi-annual meeting of the Southeast Kansas Medical Society was held at Fort, Scott, April 9, 1912. The following program was given:

AFTERNOON SESSION.

"Plaster of Paris Bandges and Their Use", Doctor Elmer E. Liggett, Oswego, Kansas.

"Acute Infection of the Frontal Sinus," Doctor Hugh B. Caffey, Pittsburg, Kansas.

"Treatment of Acute Lobar Pneumonia, with Special Reference to the Use of Guiacol," Doctor J. C. Kirby, Cedar Vale, Kansas.

"Scientific Hydrotherapy Applied," Doctor Paul Christmann, Parsons, Kansas.

"Professional Co-operation," Floyd Poe, A. M., D. D., Independence, Kansas.

"Cardiac Irregularities," Doctor C. C. Conover, Kansas City, Mo.

Clinics—Mercy Hospital. Fort Scott Doctors.

EVENING SESSION.

"Treatment of Typhoid Fever," Doctor W. C. Chaney, Independence, Kansas.

"Tubercular Meningitis," Doctor Chas. S. Campbell, Coffeyville, Kansas.

"Diagnostics and Therapeutics of the Cerebrospinal Fluid," Doctor A. L. Skoog, Kansas City, Mo.

"Appendicitis in Children," Doctor Albert Smith, Parsons, Kansas.

Our meeting at Fort Scott, was attended by about 50 enthusiastic doctors. In addition to the scientific program, we were entertained with a literary and musical program; an automobile ride, including a trip to Mercy Hospital, which was opened for inspection. An elaborate banquet was held in the evening. The officers elected for the coming year were:

Dr. Hugh B. Caffey, Pittsburg, president; Dr. J. D. Hunter, Fort Scott, secretary and Dr. M. F. Jarrett, Fort Scott, treasurer.

ELMER A MINER, Secretary.

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RESOLUTIONS.

At a regular meeting of the Second District Branch of the Kansas Medical Society, at Fort Scott, Kansas, the following resolutions were unanimously adopted:

Whereas, Our brother, C. W. Maser, has been called from the busy scenes of his life-work, to enter that bourne from which no traveler hath ever returned, therefore be it

Resolved, That it is with deep regret that we part with our professional brother, who was an active and valuable member of our society, an energetic worker, and a leader in his chosen specialty, throughout this section of country. We shall miss his wise and friendly counsel, and his genial presence in our meetings; we realize that our loss is insignificant in comparison with that of his many patients who had learned to trust him implicitly, and to seek his kindly advice and help in their time of trouble. And far greater must be the loss of his family and relatives! Theirs is,

indeed, a sad bereavement, and we know not how to express our deep sense of the heavy stroke under which they are prostrated. We trust that they will be sustained and comforted by their faith in Him who "doeth all things well."

Resolved, That these resolutions be spread on the minutes of this society, and a copy be sent to the bereaved family; and also for publication to the Journal of the Kansas Medical Society, and the Parsons daily newspapers.

M. F. JARRETT,
Fort Scott, Kansas. Signed JOHN D. HUNTER,
April 9, 1912. M. L. PERRY.

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The following resolutions indorsing the candidacy of Dr. Chas. S. Huffman for Governor of the State of Kansas, were unanimously adopted by the Southeast Kansas Medical Society at its meeting in Fort, Scott, April 9th, 1912:

Resolved, That whereas our friend and neighbor, Dr. Chas. S. Huffman has announced his candidacy for governor of the the State of Kansas, and knowing him as we do to represent the highest ideals of citizenship; from his many years of honorable service in the state legislature; and the high esteem in which he is held by the entire medical profession of the state, be it therefore

Resolved, That we heartily endorse his candidacy and without reference to party affiliations, promise him our earnest support and the use of all honorable means at our command to secure his nomination and election, and be it further

Resolved, That these resolutions be spread upon the minutes of this society of which the Doctor has so long been a faithful member, and that a copy be furnished the State Medical Journal for publication.

HUGH B. CAFFEY, M. D.,
R. M. BENNETT, M. D.,
E. B. PAYNE, M. D., Com.

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NEWS NOTES

On the morning of April 13, Dr. Clinton Beasley, Moline, Kansas, lost by fire, his office, including all accounts, library, instruments, etc. Loss $1000. This is Dr. Beasleys second fire in 15 months.

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Dr. H. C. Markham of Parsons, Kansas, has gone to Philadelphia and Chicago, where he will spend three months doing post-

graduate work on the eye, ear, nose and throat. Upon his return he will limit his practice to the above specialty.

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The automobile number of the Journal of the American Medical Association was as interesting and entertaining as ever. Many valuable suggestions can be gleaned from the discussions of the automobile in the annual auto edition.

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American Medical Editor's Association. The annual meeting of the society will be held at Atlantic City, N. J., on June 1 and 3 with headquarters at the Marlborough-Blenheim Hotel. Dr. Thomas L. Stedman, editor of the Medical Record will preside and an attractive program is being prepared. The annual banquet will be held on the evening of June 3.

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International Congress on Hygiene and Demography.—At a recent meeting in New York of the committee on organization of the coming Congress on Hygiene and Demography, a provisional program was adopted for the five day meeting which is to begin Monday, Sept. 23, 1912, at Washington, D. C. The evenings of Monday, Tuesday and Wednesday of the session are each to be devoted to some distinguished visitor. Among those who have already accepted are Sir Thomas Oliver, London, and Prof. Max Rubner, Berlin, who have consented to deliver special addresses. An invitation has also been extended to Professor Laveran of Paris. Twenty-six federal bureaus have accepted the invitation to participate in the exhibition and the Department of State has repeated its invitation to the seven states which had not accepted the previous invitation. An appropriation will be asked of Congress for the exhibition. The president of the United States will address the congress on the morning of September 23. June 1 is the latest date on which abstracts of papers will be received and July 1 the latest date for receiving full papers. Among those of international reputation the following will address the congress: Dr. Max Rubner, director of the Physiologic Institute of Berlin University, who will deliver an address to the congress on the following subject: "An exposition of the significance of hygiene and demography in the sanitary intercourse of nations with special emphasis on co-operative international work and a historic review of what has hitherto been accomplished." Sir Thomas Oliver, one of the world's authorities on industrial hygiene, has selected for his subject, "Dust and Fume, the Foes of Industrial Life." Dr. Jacques Bertillon, chief of the Bureau of Muni-

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BLADDER AND UTERINE PROLAPSE.

J. T. AXTELL, M. D., Newton, Kansas.

Address of the President at the Annual Meeting of the State Society, May 1, 1912.

It is customary in a President's address to review to some extent the medical or surgical work of the year. My personal work is limited to one field and as the last year has brought forth considerable discussion of certain subjects in gynecological surgery I prefer to limit my observations to something in which I may give you my personal experience.

Bladder and uterine prolapse has therefore been chosen as a subject. Dr. Crowell of Kansas City has lately given a quite thorough review of the discussions and opinions of various noted men during the last year. Certainly, no other subject in surgery has more opposite views expressed, and few, if, any, are more neglected in the text books. What really holds the uterus in place has long been a mooted question. Whether the ligaments of the uterus are really its supports or whether it is supported from below has equally noted men to support his side of the question. Certainly we know, as the writer has personally seen, we may have procidentia in a woman who has never been pregnant and where the pelvic floor is certainly intact. In such a case the ligaments must be at fault.

Retroversion is so common in virgins as to cause no comment. For these reasons it would seem to me that more than the pelvic floor must be involved. Our worst and most common cases, however, of cystocele and uterine prolapse, occur or are found in neglected cases of laceration, of the perineum, with a giving way of the pelvic floor, following childbirth.

This would lead us to believe that neither side of the question was entirely true and that both the ligaments and the superincumbent structures have their effect while either or both are in-

adequate in all cases. The fact is the uterus and its supports are better adapted to the position of the four footed animals than to the upright position of man. Our veterinarv surgeons have no such problems

It is usually supposed by the laity and those of limited experience that a hysterectomy would be a cure for procidentia. Experience, however, has shown that this is seldom the case and certainly it never cures the prolapse of the bladder which of the two, is the more aggravating trouble. In rewriting our pathology of the bladder, which we have had to do in the last few years, among other things retained urine in the bladder, as may come with pronounced cystocele, has taken a prominent place.

Prolapse of the bladder is often called a hernia of the bladder, and this view of it seems to me the most nearly correct. The old anterior colporraphy operation, of freshening and folding in mucus membrane over the cystocele and separating the bladder well up from the cervix and on the sides, pushing it up in the abdominal cavity, cutting out an oval piece of mucus membrane was some better, and might even yet be used for some mild cases, but mucous membrane is poor support and a large number of cases give way in a few months or years.

In cases where there is uterine and bladder prolapse, uncomplicated, some good operators are doing a hysterectomy, after dissecting the bladder loose from the uterus, stitching the round ligaments together and both of them into the stump of the uterus for support of the uterus. The posterior denuded bladder wall is then stitched up to the broad ligaments with chromic cat-gut. In other cases the uterus is left suspended by the round ligaments stitched together over the recti muscles, the bladder dissected loose and stitched up to the anterior part of the uterus.

A few years ago Watkins conceived the plan of bringing the body of the uterus down after the bladder had been dissected loose and pushed up into the abdomen and stitching the fundus of uterus up to the inner side of the pubes, where fairly strong tissue is found. The Mayos' took up the operation, doing several thousand cases and the experience has been very satisfactory.

This is the operation from personal experience of my choice and a more complete account might be of interest. The cervix is grasped by a strong broad toothed tenaculum, and brought down over the perineum. If the cervix is very long it should be amputated. An incision is then made from the cervix to about one and one-half inches back of the meatus, down to the bladder wall and the bladder dissected loose and pushed up.

Some difficulty is often encountered in getting the bladder thoroughly loose from the uterus and opening the peritoneum between the two. The movable feel of the peritoneum tells you when you are past the bladder. The hips of the patient should be slightly raised and it is seldom a bowel is seen or felt in the operation. A finger can usually enter the peritonial cavity, get above the fundus and bring it down within reach of tenaculum or catspaw forceps. The fundus of the uterus must be brought out first, and not try to bring the anterior part of the uterus first. If the uterus is small, as after the menopause, it is stitched with fundus to the symphysis pubis, taking care not to press too much on the urethra so as to obstruct it.

Redundant mucus membrane should be cut away and the edges stitched together and to the body of the uterus. A perineal restoration is done in all cases. Should small fibroids be found in the uterus, they may be shelled out. In one case the writer amputated the uterus at the neck for multiple fibroids and stitched the stump in the breach, instead of the body of the womb.

Where the uterus is large, Watkins sometimes takes out a "V" shaped piece to reduce the size. If the operation is before the menopause, a section must be made of the tubes near the uterus to prevent conception. Where an old ventral fixation has been made which still holds the uterus but allows the bladder to protrude it must be cut loose from its abdominal attachments. Opening the peritoneum at the junction of bladder and uterus will facilitate the lower operations, which should be done just afterward. This operation has stood the test of several years' time, in enough cases to call it very satisfactory.

SUMMARY.

1. Probably both ligaments and pelvic floor are uterine supports.

2. Plastic operations on mucous membranes alone not sufficient to hold prolapsed bladder.

3. Hysterectomy a poor operation where uterus and bladder both prolapsed.

4. Cystocele treated like a hernia by closing the opening with body of uterus gives permanent and satisfactory results.

MEDICAL DOGMA AND ORTHODOXY.

FRANK A. CARMICHAEL, M. D., Goodland, Kansas.

Read before the meeting of the 9th and 10th Councillor Districts, Norton, Kansas, February 21, 1912.

Under this caption I would like to venturé a few mental maunderings dealing briefly with some of the theories, beliefs and customs handed down to us from a past generation, and some that are the aquisition of the present generation. To touch upon disputes that have been settled after long and bitter controversy and contentions that are still under discussion concerning many of the fundamental theories of medicine. However, as I realize the futility of covering the ground in the scope of this short paper, I will take up in a fragmentary way only such portions as seem to be correlated to our present status as a profession, without an attempt to justify the irrelevancies that appear, as the temptation to digress is strong.

In the pursuit of knowledge, in the formation of scientific bodies, as well as in the building up of a program for a medical society meeting, there is usually a certain sense of security, of enforced harmony, due primarily to the knowledge that each essay presented, each argument offered and each conclusion reached is the offspring of precedent. That is, we feel that the essayist, to sustain his contention, or the antagonist who opposes his views, is prepared to revert back to prior conclusions by a more marked authority for corroboration of the theories or contentions they champion or oppose and the citation of this authority ends the controversy.

From such blind deference to the opinions of our predecessors the fetters of dogma are forged, from such unquestioning subservience to established method and custom, the spirit of orthordoxy is born. So closely and so completely do these conditions restrict our every thought and act that escape from them seems impossible. If we attend a confinement, reduce a fracture, or handle a surgical case, a certain rule and routine must be observed, both in the performance of the work and the after care of the case, otherwise we are open to public censure or a malpractice suit.

Originality along any line of thought enjoys a delightful irresponsibility. There are no authorities to be looked up and cited, no precedent to be followed or custom to sustain, yet an unreasoning timidity, a phobia of the ridicule of the vast herd who

daily and hourly agitate the dust along the well beaten pathway of established thought and precedent prevents the voicing of thoughts and enunciation of theories that run counter to the tide of public conviction. Were it not for this timidity on the part of many members of the medical profession, our medical journals would contain much more that is original in thought and much less of proxility, plagiarism and clever rearrangement and grouping of the thoughts and ideas of others.

It is not the intention of this paper to seek to detract in the slightest way from the value and importance of previous work and discovery, but merely to call your attention to the fact that so soon as we attempt to make the achievements of the past the unquestioned standards of the present, we cease to progress until some daring spirit voices a new thought or proves a new conclusion.

Dogma is the curse of all creeds because it permits no deviation from a set rule or standard, prevents advancement and offers a formidable obstruction to progress. Real achievement never follows in the footsteps of precedent but boldly cleaves its own pathway from logical hypothesis to proven conclusion.

One who departed from orthodoxy in the early christian era was branded as a heretic and excommunicated, scourged, imprisioned or slaughtered, according to the extent of his heresies.

To-day these conditions do not exist because sectarianism became the natural sequence of repressed thought and censored opinion. Because exponents of every new creed and cult won instant sympathy and adherents merely through the expression and espousal of independent thought, until time has demonstrated the wisdom of occasionally revising our tenents of faith to meet the requirements of changing social and economic conditions.

From the orthodoxy of the Galenic code, homeopathy had its origin and from these two factions at constant variance with each other as to cause and effect, the electic school was born, which essayed to select the best from the other two, rejecting the (to them) objectionable features. Yet all these being distinctly medical cults with a profound faith in the all curative power of drugs, oftentimes ignored or failed to recognize the tremendous importance of physical and psychic elements in the cause and cure of disease. Failed to take into consideration that while the ultimate trend of the human mind is toward advancement and a higher plane of thought and reasoning, there are occasional psychologic eddies that tend to sweep us back in reversion to more primitive ideas and beliefs. Hence, quackery, the patent medicine curse,

the manotherapist, magnetic healer and the christian scientist sprâng into existence to meet and to fill a psychological need.

Each of these have prèyed upon the mental qualities of weakness and atavism and waxed fat and strong in adherents, while the practitioner of medicine, with his eyes firmly fixed upon the ideals of his creed and feet firmly planted on a platform of precedent, is traverseing a path of ever increasing obstacles.

With the vast financial resources of the patent medicine interests arrayed against him in his attempt to secure legislation protective to the public health and thereby attack the evils of disease at its very root, with the pernicious activities of non-medical and religious sects to re-shackle the minds of people of to-day with the bondage of beliefs and superstitions of a past replete with dogma and disaster, from whence are we to derive our inspiration and zeal for the prosecution of the work of enlightenment we have undertaken? Only through the fellowship of free discussion and the unity of perfect organization.

In the medical profession itself, many evils have sprung up, born of the avarice, cupidity and petty jealousies of an overcrowded calling, that have done much to undermine our code of professional ethics, to detract from the value and renumeration of our services, to lower and vulgarize us in the eyes of the laity and pave and make smooth the way for the quack and the charlatan.

The admission to the ranks of the profession of many in whom the commercial out-weighed the professional quality has brought about certain changes in the regime of medicine tending toward commercialism. Making competitors of those who should have been colleagues and commercial antagonists of those who should be co-laborators in a great cause.

The profession has always been divided into two grand classes —the competent and the incompetent. The former have been so engrossed in the professional and scientific aspects of their calling that they have failed to direct their energies to the suppression of the evils growing up around them, and the latter having neither capacity nor taste for progression along professional lines, have prostituted their calling to their financial interests. Thus the profession became possessed of the advertising abortionist, the commercial surgeon, the knocking consultant, the medical parasite who clings to his patient until he has extracted the last drop of financial gain he can extract from them, and a host of other vermin equally unclean and nauseating.

This is our profession of to-day, not as we, who are "on the inside looking out" see it, but as many who are "on the outside

looking in" view us—as we are viewed by many of the laity and as we are pictured by the non-medical and sectarian cults. Does it look clean, healthy and wholesome to you? If not, what are you going to do about it? With the exactions of higher preliminary requirements on the part of our medical institutions, with the abolition of the commercial medical school, and the diploma mills and the facilities for frequent comingling and exchange of thought offered by our medical societies, it would seem that the remedy for these evils is now within our own hands, and the moral, fraternal and scientific functions of the profession as a whole tremendously benefitted and improved.

Are we going to improve them? Do the great rank and file of the profession feel a deep interest in their improvement? Is the profession at last going to rouse from its lethargy and prove its right to the confidence and respect of the people in the fullest degree?

I will venture the assertion that not ten per cent of the enrolled membership of the combined societies meeting here to-day are present. It is my honest conviction that at least 75% might have been here without great financial loss or unusual inconvenience. Does it look as though the profession of our district stands for progression, fraternity and the crying need of the hour—ORGANIZATION.

Of what value to those who do not attend these meetings are the proceedings and discussions of this society and of what value to the society is the member who never attends its meetings? Every district and every locality has its quota of physicians who cling to the early dogma of medicine with the blind devotion of the zealot. Men who oppose vaccination, antitoxin, animal experimentation, and who regard the minutia of modern clinical training as a purely spectacular and theoretical embellishment who can see no value accruing from a community of interest among the profession, who can neither be coaxed or bribed into affiliation with a medical society, whose books have become dusty and cobwebbed from disuse, as they have turned from Aesculapius to worship at the shrine of Mammon, and whose minds have become overgrown with the fungus of an orthodoxy long since recognized as fallacious and looked back upon only as one of the milestones marking the forward progress of their profession.

You will find that these are the men who believe that there is nothing new under the sun because they have sought nothing new, but have been contented with the teachings and the dogma that are now obsolete. Were this class to be composed of older men

in the profession, one might be tempted to make some excuse, but far too frequently we find them among the younger element, men who should be in the flower of professional life with minds so full of the idea of becoming (financial) captains of the medical industry that they have neither time nor sympathy to waste on the vagaries of their deluded brethern, who deem an organization and an occasional exchange of thought essential to the progress and quality of their work.

As an asset or adornment to the profession they (mis) represent, they are as valuable as mammary appendages on a male pig. How are we to interest this indifferent element, gain their confidence, rejuvinate their professional loyalty and professional pride and enlist their efforts in farthering our common cause?

Our medical society, and by this I mean our county or district medical society, with which we should be personally and intimately identified, is the nucleus around which the most stable, helpful and scientific establishment of our art is builded. Its potential influence is for the promotion of harmony, the dissemination of knowledge and exchange of experience and thought, both through its scientific programs and by personal contact of its members, and the preservation of the honored ethics of practice. Without its broadening influence, and the stimulus it begets to greater effort, broader aims and worthier achievements, our views are apt to become narrow and distorted, our aims selfish and sordid and our conception of professional ethics obtunded. As an example, here is reproduced the professional card of a practitioner in this state, appearing in the weekly paper, where there is no county organization:

DR. J. W. SHEPARD,
LEOTI, KANSAS.

Practice in 8 counties, have been here eight years, have taken six patients to hospital and all recovered; have never lost a case of typhoid fever. Mortality almost nothing in all diseases. Never too busy to stay with bad case until medicine acts. : : : : :

Good Automobile Service
YOUR BUSINESS SOLICITED.

How vague and indistinct the line separating ethics from quackery. Could the most daring charlatan, the most conscienceless grafter the most finished fakir put forth more absurd, extravagant or misleading claims? And yet, this man is presumably a recognized member of the medical profession. How proud it would make the alma mater from whose dim halls of learning was launched upon his proud career of conquest, this therapeutic Goliath, who so modestly flings his banner of "Excelsior" to the toying zephyrs of our great state, to know that it is the parent of a genius who defies death and subdues all disease, whose "Mortality is almost nothing in all cases." Nothing so clearly emphasizes the progress of profession along the line of ethics as the attitude of its members toward this type of advertising. Twenty years ago, such a card would hardly occasion comment. To-day we can view it only as an unsightly blot on the ethics of an honorable calling and an insult to the intelligence of our laity.

The A. M. A. will continue as the official head of the organization of this country, each state will have its organization and the cities will have their societies supported by earnest and sincere workers devoted to the advancement of their profession, but the profession will never become a perfect unit until there is a perfect unity in its component societies—until each county and district society can count its entire membership in ACTIVE membership, pledged to its welfare and progress and willing to make personal sacrifices and endure personal hardship to assist in its maintainance and to assure its success.

Pleading and exhortation have alike failed in our society, to awaken interest or promote better attendance. Our paid up membership is but 25% of what it was four years ago. We have held meetings in towns centrally located and easily accessible to all members and have not had sufficient members present to transact business, even the physicians in the town in which such meetings were held, not deeming them of sufficient interest or importance to induce them to lay aside their work for a few hours to attend them. After long and urgent solicitation, we have secured the promise of members to present papers or appear on the program in discussions who have made a religious duty of absenting themselves without excuse or apology from the meeting toward whose success they had promised to contribute, thereby crippling our programs and disappointing members who had attended in the hope of participating in a successful meeting. Under such conditions and with such support could you expect any enterprise to succeed?

I make no apology for this digression, for as I said in the introductory portion of this paper, the temptation is strong, but to come back to the subject we were discussing—you will note that Pare, Semmelweiss, Flint, Lister, Metchnikoff, Koch, Pasteur, and all the shining galaxy, who by their tireless energy and profound study have raised the art of medicine from the depths of a bigoted and pernicious superstition supported by custom and credulity, alone, and placed it upon its present lofty pedestal, fortfying it by incontestable proofs, its rights to existence, were compelled in the very inception of their efforts to depart widely from the accepted teachings of the day; otherwise, we would still be dispensing amulets, charms and potions and all the pseudo sorceries of our ancient brethern. And it is a significant fact, even in this day of advanced thought, that the richest embellishments of medical progress have been gathered far from the beaten paths of accepted thought.

As typical of more recent departures from established doctrine in medicine, may be mentioned the success attendant upon the administration of antitoxin, by the mouth as reported by Cumberledge, the highly favorable results accruing from the elimination of meats and the substitution of glucose, starches and starchy foods in the treatment of certain types of severe diebetis by Klemperer, the advance in the elucidation of the etiology of goitre which point strongly to the fact that certain types at least are plainly of gastro enteric origin, and the contribution of Wasserman on the selective and specific actions of the salts of selenium and tellurium on the cells of cancer.

In conclusion, let me urge that we take a greater and more active interest in our society, that we be willing to devote our time and our talent to its support. Become an ACTIVE member, bringing into our society for discussion, the fruits of our independent thought, for every worker in the great field of medicine should be an independent thinker and should cultivate that quality of logic that will enable him to champion his views and opinions by sound argument. In this way only may we be considered an active unit in the great scheme of medical progression. We must not be content to merely follow, meek disciples of the thoughts and theories of others, but should recognize the fact that precedent is not progress—that it is not always a help, but quite frequently a hindrance.

As a vocally active and physically imposing member of this society once sagely remarked, "It is better to be whipped than not to be noticed." It is better to have our professional friends an-

nihalate our pet theories and throttle our pet hobbies and then hold a respectable wake over the remains than to have blundered through our allotted days without our minds having conceived an original thought or our voices been raised in a single sentence out of strict conformity with public opinion.

Therefore, let us meet—let us ALL meet in the spirit of true fraternity and mutual helpfulness. Let us bring our theories beliefs and opinions, the children of our individual mental efforts, that they may receive their baptism of approval from our colleagues, if they be found worthy, or be given at the hands of this society, the last sad rites accorded the worthless and fallacious.

Who among us wishes to carry enthroned in his confidence, the mummified foetus of an erroneous theory—who wishes to be the parent of a mental "monster par defectum?"

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TYPHOID CARRIERS.

SARA E. GREENFIELD, M. D., Topeka, Kansas.

Read before the Shawnee County Medical Society, May 2, 1912.

It is only a few years ago, since we began to hear about the typhoid carrier. About four years ago the newspapers exploited the fortunes and misfortunes of "typhoid Mary." This was the first that the public had heard of such a thing and no doubt it was the first time that many of the profession had heard of it as well. "Typhoid Mary" was a cook who managed to give the disease to twenty six persons in eight different families before she was apprehended. These cases followed so fast after this woman's entrance into a home that it caught the attention of the medical world which was then rather slow to recognize the condition.

Horton Smith in his Gouldstonian lectures in 1900 was the first to suggest the advisability of studying the excretions of ex-typhoid patients as a possible cause of outbreaks of epidemics. Parke, baseing his conclusions on the investigation of fifty-two patients examined eight months after recovery, thinks that 2% of all typhoid patients become chronic carriers. Klinger, investigating an epidemic in South Germany in 1910, was able to trace to their source, 397 cases or 36% of the number of entire cases investigated. In 1272 cases the typhoid convalescent carrier was found to be the cause and in 125 the healthy carrier was the same. Considering all patients as chronic carriers in whom the bacillus had been demonstrated for at least three months, it was found that out of 431 carriers, 211 were temporary and 220 were

chronic carriers. In thirty of the chronic carriers cholecystitis was present. The temporary carriers were mostly young, the chronic carriers were old or middle aged.

Typhoid bacilli have been frequently found in the gall bladder at autopsy. Miller of Johns Hopkins reported a case in which typhoid germs were found in the gall bladder seven years after the occurence of the disease. Dungern of Munich cultivated them from an inflammed gall bladder fifteen years after the disease and Zinsser observed an operation for gall stones seventeen years after the patient had had typhoid fever, where typhoid bacilli were found in the gall bladder.

Typhoid bacilli have been isolated from the urine many months after an attack. It is said that albuminuria is present in these cases and that the bacilli appear and disappear with the albumin -uria.

They have been found in the sputum and in these cases there is usually an accompanying bronchitis, broncho-pneumonia or pleurisy. From the hygienic standpoint, the sputum is not a great source of danger.

The prostatic gland has been the seat of the infection. Marchildon reported two cases in 1910 of typhoid prostatitis and seminal vesiculitis.

The gall-bladder is the place par excellence for the propogation of the bacilli. Here they grow outside of the body tissue in the bile Bile is an excellent culture medium, so there is no reason why they may not remain indefinitely in this locality. The feces of such a case must of necessity contain the infection.

The opsonic index is said to remain high in chronic carriers. The Widal reaction usually persists. Some observers have reported cases where the Widal reaction did not persist. The May 4th, 1912 issue of the Journal of the American Medical Association reports the finding of a typhoid carrier on board a ship where suspicion was directed to the case by the presence of the Widal reaction in a dilution of 1 to 160. It seems to me that the reaction does persist in so great a number of cases that it should be turned to practical account. Persons who have had typhoid fever one year or more before the test is made and whose blood still shows sufficient agglutinin to give a reaction in a dilution of 1 to 50 or more ought to be held for farther investigation.

The isolation and identification of typhoid bacilli from feces, urine or bile is a difficult problem. Far too difficult for any but persons with considerable experience and who have plenty of time at their disposal. If we had a differentiating stain like we

have for tubercle bacilli, or if we could identfiy the germs under the microscope by their morphology as we do diphtheria, things would be different. But as it is, we have to depend almost entirely upon the various culture reactions no one of which is wholly satisfactory, and no one of which unsupported by other tests can prove the presence of typhoid bacilli.

In order that you may appreciate the magnitude of the undertaking, I will give an outline of the steps necessary in the procedure. The feces and urine contain a great many germs besides the typhoid bacilli and the first problem which confronts us is to find some medium on which to grow cultures from the feces or urine which will inhibit the growth of all but the colon group, that is the bacillus coli communis, and the bacillus typhosis. The colon group will withstand a greater amount of antiseptic than other bacteria which are found in the feces and urine so various culture media have been devised all containing some kind of an antiseptic. Having succeeded in inhibiting the growth of nearly all but the colon group, we are now confronted by the problem of finding a way to differentiate the colon group, that is to separate the coli communis and the typhoid bacillus. The coli communis is sure to be present whether the typhoid is or not. A great many special media is now offered. It looks as if every bacteriologist of any note has a special medium of his own. There is the Hiss medium, the Hesse medium, the crystal violet medium, the Endo medium and a host of others. All of which prove that no one of them is a perfect medium. Now having chosen one of these media, say the Endo medium, cultures on Petri dishes are made to separate the coli and the typhoid, On the Endo medium, the coli communis grows as a red colony and the typhoid as a colorless colony. Now if there were no other germs which could possibly grow on this medium, our troubles would be at an end, but such is not altogether the case. A few other germs will probably creep in and all colorless colonies cannot be called typhoid colonies, but must be proved by other tests. They must be inoculated into fermentation tubes containing, lactose, dextrose, maltose and levulose, as well as into milk for the acid test and the coagulation test. Tests should also be made for indol, and finally a culture should be grown on agar for the last test of all, the Widal reaction.

I have given you this outline in order that all may know the nature of the work. It is expert work and does not belong to the ordinary routine laboratory work. It is in the field of research and I think it must remain there for some time to come. If it

is ever demanded to any great extent, it will necessitate a large corps of workers.

In the vicinity of Peabody, Kansas, there lives a woman who, as a typhoid carrier is rather unique. Instead of disseminating the disease in the usual manner through the feces, has been scattering it directly through the bile. This woman had an attack of typhoid fever seven years ago and following the attack she had gall-stones. This is said to be a rather common sequel of typhoid fever. She was operated upon for the stones and a permanent fistula remained, through which the bile flowed. She had to keep a dressing over the opening and as she changed it, her hands became soiled with the discharge. She was a housekeeper and it requires no stretch of the imagination to explain how she infected others. Last summer the people of that vicinity had a picnic and this lady contributed her share of the food. It is said that she brought some pressed chicken. It is thought that this chicken was the cause of the subsequent trouble. Following the picnic a number of persons were taken ill with symptoms of typhoid. Dr. Johnson of Peabody, had the care of a number of these people and as he was the family physician in this woman's home he knew of a number of other cases which had occurred, which could all be traced to some association with this woman.

Some of the bile was sent to the state board of health. Other samples were sent to university hospital at Rosedale, and to a laboratory in Chicago and to one in Detroit. The first specimen with which I had anything to do, was the best specimen which I ever received from the case. Actively motile organisms could be seen in a drop of the bile under the micorscope and cultures from this specimen were easy to make.

Other samples were not that way. In fact, some of them showed no motile organisms, even from the special cultures. Ordinary pus germs and the coli communis were all that could be found in these samples.

The reports from the bacteriologists to whom these specimens were sent did not agree. Some found typhoid and others were equally sure that no typhoid was present. I believe that all were correct in their reports. In looking up literature on this subject, I find that the discharge of typhoid bacilli is often intermittent and I am sure it was true in this case.

We had the pleasure of having this case verified by Dr. Anderson, director of the Marine-Hospital Service at Washington. Dr. Anderson's examination was made about two months later than the other examinations. In his letter Dr. Anderson said

that he found typhoid bacilli. That all of the cultural tests had been fulfilled and that he had isolated them in pure culture and had made a Widal reaction with them.

Another interesting feature of this case was that this woman's blood gave the Widal reaction. I obtained a reaction with a dilution of about 1 to 60, and Dr. Cardiff of Washburn, whose valuable assistance I wish to acknowledge, was able to get a good reaction with a dilution of 1 to 200. Dr. Cardiff was able to get the reaction not only with typhoid but with paratyphoid as well.

After the report from Washington, an attempt was made to close this fistula, with what success I have not heard. If it was a success, they have succeeded in making an ordinary typhoid carrier out of her. She will still discharge the bacilli through the feces, and will still be more or less of a menace to the community. It has been suggested that perhaps typhoid vaccination might overcome the condition. But this remains to be seen. The germs are growing in the bile as saprophites, and may not be affected by the typhoid vaccination.

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ACUTE INFECTION OF THE FRONTAL SINUS.

HUGH B. CAFFEY, M. D., Pittsburg, Kansas.

Read before the Southeast Kansas Medical Society, at Fort Scott, April 9, 1912.

The frontal sinuses belong to that group of accessory sinuses known as group 1, and occupy the more anterior positions—the others of this group being the maxillary sinus or antrum and the anterior ethmoidal cells. The other, group 2, is situated further back and comprises the sphenoidal sinus and the posterior ethmoid cells. It may be interesting to note that there is a complete set of all of these sinuses on each side of the nose and that they communicate with the nasal cavity and drain their contents into this cavity by openings which can be demonstrated in the living subject. The true function of the sinuses is as yet a subject of wide discussion, but we know that an important function is to furnish resonance to the voice, and by their secretion of mucous, to assist in keeping the respiratory tract moist. The frontal sinuses are the largest of the sinuses, expect the antrum and extend between the plates of the frontal bone, from the root of the nose upward and outward, following closely the line of the eyebrows. They are rarely of the same size and never communicate one with the other. They are divided by a thin septum of bone and are lined with mucous membrane continuous with that of the

nasal cavity. They open and drain into the upper part of the nose through the groove lying under the middle turbinate, called the hiatus semilunaris. This groove also contains the openings of the antrum and the anterior ethmoid cells. By this brief description I have tried to picture the frontal sinuses as two blind cavities (like the appendix for instance), situated so that they are in direct and constant communication with the nasal cavity and also like the appendix the system is perfect so long as there is no obstruction to the normal flow of secretions, but if from any cause, the duct is closed an acute infection takes place. The causes of acute sinusitis, are then, identical with the causes of acute rhinitis; it is, in fact, nothing more than an extension of the infection from the nasal cavity, through the continuity of its mucous lining, to the mucous lining of the sinus.

It is rare to find frontal sinus disease in any person under 15, since the sinus does not begin to develop until the age of seven. The same bacteria concerned in acute rhinitis are responsible for the infection of the sinuses. Usually the bacillus of lagrippe is the cause, and the disease is much more prevalent during "grippy" seasons.

The first symptoms complained of are those of an acute cold, soon followed by frontal headache, over the side affected, sometimes extending over the entire head. The pain is increased by stooping forward, coughing, blowing the nose, or any sudden shock or jar. The pain is worse on awakening from sleep, due to the recumbent posture interfering with drainage, but is somewhat relieved by assuming the erect position. On suddenly rising up dizziness may be complained of, but I do not regard this as an important symptom in all cases. On account of the free anastomosis between the veins of the sinus and the opthalmic vein, various eye symptoms such as photophobia and diplopia may be present. This is especially liable to occur where the drainage is completely stopped and the intrasinusoidal pressure is raised to a marked degree. So much for the subjective symptoms. The objective symptoms are less pronounced to the general practitioner, because there is very little to see externally and even internally, unless one has a good reflected light, and posesses some dexterity in the manipulation of nasal instruments. Redness and swelling over the frontal sinus is not seen unless the case has progressed to a pus condition, with a resulting periostitis. Pressing on the floor of the sinus at the anterior internal angle of the frontal bone will sometimes elicit pain and aid in the diagnosis.

In the vast majority of acute frontal sinus cases rhinoscopic

examination will reveal a deflected septum or an hypertrophic rhinitis, both chronic conditions, but aggravated by the acute "cold in the head." By rhinoscopic examination we can see whether the middle turbinate is swollen and pressing on the naso-frontal duct, and in case pus has formed in the sinus it may be seen trickling down under the middle turbinate in the middle meatus. There might be some doubt as to where the pus comes from and in that case transillumination is necessary. This is done by asking the patient to hold a light in the closed mouth, in dark, covering both the head of the examiner and the patient with a black cloth. All the cavities are thus illuminated, and the one containing pus or is congested from an inflammatory process, looks dark and more opaque than the rest. Once the diagnosis is made the treatment for an ordinary acute infection of the sinus is exceedingly simple, and generally, very effective. The first thing to do is to the swab the nasal cavity with a weak solution of cocain and suprarenal extract which has two useful purposes, first, it shrinks the engorged turbinates so that a detailed inspection can be made, and second, it anesthetizes the hiatus so that a probe may be passed into the sinus opening if this is deemed necessary. After being assured that the sinus is draining properly an alkaline spray for the nose and a prescription for quinine and aspirin and a laxative will usually produce excellent results. The local treatment may have to be repeated in twenty-four hours or even for the third time as I did in one case this winter, but in most of the acute cases one thorough treatment will give relief from pain and if followed up by the after treatment outlined no return of pain is to be expected.

It is beyond the scope of this paper to take up purulent inflammation of the sinus where surgical measures are necessary to relieve. I have tried only to speak of the acute infections that we meet in everyday practice and especially, as I have said before, during an epidemic of lagrippe such as we have had this season.

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VERSION—WITH REPORT OF A CASE.

E. A. REEVES, M. D., Kansas City, Kansas.

Lecturer on Obstetrics, University Medical College, Kansas City, Mo.

Read before the Wyandotte County Medical Society, May 12, 1912.

In beginning, I will say that I have thought little of this procedure, until the last two or three years, but, after losing two babies and having badly lacerated women in two cases of forceps deliveries in occiptio posterior position, concluded to try version.

I have done this operation four times in the last two years—twice with, and twice without anaesthesia—with perfect results, having five living babies from the four cases and no perineal laceration in any case.

This operation, briefly defined, is the artificial changing of the position of the foetus in utero. It is probably the oldest obstetric operation and has been practiced from the earliest history of obstetrics.

We have four methods of performing version: 1st. Postural. The woman is placed in such a postiion that gravity will correct the mal-position of the child, a very simple and safe procedure, but often not a success. 2nd. External. Where by manipulation, the position of the child is changed, also safe but not easy, and can only be accomplished where the abdominal wall is thin and not irritable, a considerable amount of fluid within the uterus, and a non-irritable uterus. So, it many times fails. It is used chiefly where mal-position has been discovered sometime before expected confinement, to correct same. Then pads are used to hold the child in the desired position, until the engagement of the presenting part. 3rd. Combined. Where one hand manipulates the abdominal wall while one or two fingers are introduced into the vagina to assist in changing the presenting part, used chiefly in face or shoulder presentations, but is difficult to perform, and, after trying repeatedly, we may have to resort to the internal method. 4th. Internal. Where the whole hand is inserted into the uterus and the position of the child changed.

Bi-polar version, where the child is turned completely and one pole substituted for the other; cephalic or podalic, according as the head or feet, are brought to the cervix.

Doubtless, the most important method is internal podalic version. Before it came into common use, obstetricians believed the only way for a child to be born was by the vertex, so, every means known was used to change the false position to vertex. If this could not be accomplished, the child was torn in pieces with iron hooks, and before the advent of forceps, version was the only artificial means of delivering an unmutilated child.

Podalic version is indicated in two great groups of cases: in transverse or oblique presentations,and in vertex presentations, where delivery can be accomplished more rapidly and safely by version.

The necessity for version in transverse or oblique presentations is obvious, as the child cannot be delivered in these false positions, and, if left alone, means death to both mother and child. In

abnormal head presentations when face or brow presents, or occiput posterior positions, delivery is accomplished more easily, safely and quickly in this manner than by any other means.

Podalic version is usually the operation of choice in eclampsia where the head is not engaged, prolapse of the cord, placenta previa and premature detachment of the placenta. Where immediate delivery is required and the head is above the superior strait, version is usually a safer operation than high forceps. Also, is this true in occiptio posterior presentations, provided there is no disproportion between the size of the head and the pelvic outlet. Its widest field of usefulness is after manual dilitation, especially in eclampsia and ante-partum hemorrhage from any cause. Where the life of both patients depends upon immediate delivery, version and extraction are undoubtedly the best and safest procedure.

The best time to perform this operation is soon after the rupture of the membranes, before the fluid has drained away, and the child is easily movable in the uterus. As a rule, podalic version should not be attempted through an undilated os except in placenta previa, but, if delayed too long, until tetanic contraction of the uterus takes place, it may be difficult or impossible to turn the child and there is great danger of rupture of the uterus.

As for technique, the patient should be prepared as for any other obstetric operation, placed on a table with legs flexed on thighs and thighs on abdomen, the legs and abdomen should be covered with sterile towels or sheets.

Podalic version may be accomplished either by internal or combined method, internal preferable. In either case, the free hand must be over the fundus of the uterus to control the movements of the child and guide the head as it passes from the cervix to the fundus of the uterus.

In head presentations, the hand introduced into the uterus should be governed by the position of the limbs of the child. When the back of the child is to the mother's left, the left hand is inserted into the uterus and vice versa. If possible, grasp the anterior foot, as traction upon it will rotate the back to the front, a position most desirable for the delivery of the after-coming head. In transverse positions, care should be used not to make traction in such a manner as to cause the back to rotate posterior, as this, again, may cause trouble with the aftercoming head. Sometimes, in transverse positions, there is prolapse of an arm or may be, of the cord. These can usually be replaced without damage to the child. If the child is to be extracted immediately after version, firm pressure must be made over the fundus of the uterus to prevent extension of the head or arms.

Prognosis for the mother.—If in good condition at the beginning of the operation, is usually good; but if attempted after the fluid has all drained away, and the uterus is tetanically contracted around the child, there is danger of rupture of the uterus and death.

Prognosis for the child.—Usually good, but if the os is not completely dilated, it may contract down around the child's neck and cause death by asphyxiation, or delayed deliveries, pressure on the cord may cause the same result.

Podalic version is an operation of great value to the obstetrician, and, with care, is, in my opinion, a better, easier and safer procedure than high forceps for the conditions that may call for either operation. If done aseptically and at the proper time and with the proper skill, is practically without danger to mother or child and gives results very gratifying to both patient and physician.

Case Report.—Mrs. R., age 28, primevia. Was called early in the morning of January 8, 1911, she, thinking herself in labor. On making examination, found membranes intact and cervix dilating satisfactorily, but could feel nothing but limbs behind the membranes. Suspected twins but could not certainly find two fœtal hearts, but did diagnose transverse position and so informed the husband. The pains increased and dilatation continued until about eleven o'clock, when I found dilatation complete and the membrane yet unruptured. We called a nurse from Bethany Hospital, Dr. Pearson, to give the anesthetic and prepared to deliver the patient by version. Under complete anaesthesia, introduced hand into the uterus, and found two babies, both in transverse position, one, anterior and a little below the other, one, head to the left of the mother and the other to the right.

Ruptured the membrane and before the fluid had drained away, grasped the anterior foot of the anterior child and drew it through the cervix without much difficulty, and very soon, completed the extraction of the child.

On again examining patient, found another child and another sack with membranes intact, which I ruptured and grasping both feet, turned this child easily, since the birth of the first had given considerable more room to work. Extraction was done, the placenta delivered by Creda method and the patient allowed to come out of the anaesthetic. There was absolutely no tear of the perineum and both babies and the mother passed through the puerperium without a single complication.

MEDICAL EDUCATION IN KANSAS.

S. C. EMLEY, A. M., M. D.

Read before the Kansas Medical Society, May 2, 1912.

Fame, honor and renown, have, in the past, been associated with the achievement of great financial success, with oratorical ability and statesmanship, with the desolation and destruction of war. Fame, honor and renown were not for the man who could ease the pain of the suffering, bring joy and health to the invalid, cure the sick or prevent the ravages of the pestilence.

The protection of humanity from hidden dangers and unseen foes, the betterment of conditions under which we live, the accomplishment of things that make for human happiness and the increment of human life is to me the most engrossing, and, next the saving of souls, the most important and the most laudable vocation in the world to-day. Medical discoveries of incalculable value, ofttimes, the sole result of a lifetime of arduous and unremitting labor are freely, joyfully and naturally, as a matter of course, given with no thought of reward to an ungrateful and unappreciative world. For such benefactions honor and emolument are seldom asked and rarely given.

When civilized people realize the relative value of man and animal, of life and property, of human rights and property rights and acknowledge that upon the vigor and vitality of the citizen, more than upon anything else, depend the progress and prosperity of the nation, then, and not until then, will the man of healing be accorded proper recognition and have adequate voice in law and government. As physicians, therefore, it is our province, even our duty to impress the people with the importance of personal hygiene and public health and to be less modest in stating our relation thereto.

Present tendencies are in such direction. Note the campaign against tuberculosis; the education of the laity by our boards of of health in matters of pure food, pure drugs and pure water; the establishment of departments of public health in different universities: the co-operation of universities and municipal and state boards; of innumerable lectures, newspaper and magazine articles for the promotion of health and most significant of all the opening of the county medical society to the public.

Upon the next generation of medical men we must depend to transform these tendencies into established customs. Whether they can or will do this depends upon their present training and education. Thanks to the Carnegie foundation, the council on medical education and the association of American Medical Colleges all working harmoniously together, we of the present generation are privileged to see medical education rising from the disorganized, mercenary commercialism of the past and taking on new strength, new dignity and new force. The physician's literary education is being broadened, his scientific knowledge increased and his clinical training being made more accurate and more logical. Mental and sociological requirements have been rapidly raised and the time is now here when the physician takes his rightful place in the social, professional and political life of his community his state, and his country.

Medical education in Kansas is just emerging from adolescence. In 1889 the Wichita Medical College was still-born, but the men who know the causes are chary about giving the reasons. The Kansas Medical College at Independence lasted only through the critical second summer, dying in 1876 after sending forth two graduating classes in its two years of existence. The Kansas City College of Physicians and Surgeons, founded in 1894 and the Kansas City College of Medicine and Surgery founded two years later, being more fortunately situated, lasted until they merged in 1905 with the Medico Chirurgical to form the present Kansas University School of Medicine. The Electic College of Medicine and Surgery, which was in Kansas City, Kansas, found the soil of Missouri more congenial and moved thence some time ago, so that there are now in the state only two schools alive and thriving —Washburn and K. U. The state school had its beginning in 1880 with one year of medical work. At the age of 19 it added another year and in 1905 with the acquisition of the three Kansas City Schools (and much woe and tribulation), the two clinical years at Rosedale were added making a complete medical college with three fine buildings, including an up-to-date hospital and a well equipped laboratory building for clinical teaching exclusively.

Although of more recent organization (1890), Washburn developed more rapidly and, with easy entrance requirements and only 18 months of work for graduation, degrees have been granted every year since 1892. Now she requires a year of college work for entrance and four years of 9 months each, for graduation. K. U. requires two years for entrance and four years of 9 months each for graduation, with a decided tendency to make

the A. B. degree a requisite for entrance. But if another year is added, I trust it will be at the end rather than at the beginning and in the way of practical hospital experience rather than more of an already adequately extensive theoretical knowledge.

Both schools are members of the Association of American Medical Colleges, and the methods of instruction in each are similar except that while the university lays special stress on the scientific branches, Washburn places particular emphasis on the clinical. Few of the Washburn Instructors are on full pay while all those (except two), at the university give their whole time to the freshmen and sophomores. In both schools there is a tendency to separate the teaching years into scientific and clinical—as if the clinical were not also scientific.

The segregation of laboratory and clinical workers is unfortunate because there is a difference of viewpoint of teachers who are in active and successful practice and those who are largely non-medical, and separated as they are, they have only rare opportunities of meeting each other, forming personal acquaintances and freely exchanging views and opinions. What seems important to one—as for example the prolonged observation of mitoses in all its details—may seem irrevelant to the other. On the other hand the scientist is apt to minimize the clinicians work and regard his endeavors as crude, bungling and unscientific, when as a matter of fact the successful physician is the one who is wise enough to apply scientifically all the known facts bearing on a particular case and by so doing, cure or prevent disease. Then the clinicians accuses the pure scientist of being narrow and losing the relationship between his work and its object—the training of medical men for the practice of medicine—and of teaching his subject for itself alone, forgetful of the end in view. The clinician feels that the knowledge imparted during the first two years should be co-ordinated with that of the last two; that physiology should be taught, not from the standpoint of physiology, but from that of its application to internal medicine; pathology and anatomy, not from the viewpoint of pure pathology or pure anatomy but from ultimate purposes of diagnosis and surgery. Teach chemistry scientifically but always to medical students with its practical utility in mind. Much time is wasted in the pure sciences by the exposition of doubtful theories and speculative hypotheses, which muddle the understanding, rather than give the student a clear conception of the facts known to be true by repeated proof and established by years of usage.

All admit that the one great aim of medical education is to

train the general practitioners to heal the sick and prevent disease —after this it is well enough to train the teacher of medicine and the investigator for further advances in the misty frontier of medical science. Too often it seems to me, the clinician and the scientist both go about their teaching as if they expected all their students to become specialists or research men in the subject which in their enthusiasm seems all important to them. Too often in their zeal they lose sight of the real object of their instruction and of its bearing on the later activities of the student and forget that the majority of the class will be general practitioners in small towns.

In Kansas the tendency seems to be to employ research men, not only in theoretical subjects, but in clinicial as well, although very rarely does a man combine in himself valuable research powers and teaching ability of a high order. Usually a man is selected because of some special investigation and his qualifications as a teacher entirely overlooked. For research it is enough that he be a scientist, but for teaching medical students he must be a good physician as well; able to select and acquire all the trustworthy facts of the investigators and to impart that knowledge in a clear, forcible and attractive manner to the student. I do not believe that the essentially research man is a success in teaching undergraduates at all, because he talks over their heads and seldom comes down to their plane of understanding. Search your minds for the men you know who are of really investigative characteristics—how many of them are what you would call genial or sociable?—qualities quite necessary in the successful teacher. Most of them seem exclusive and the majority are irritated by the presence of the student and annoyed by the simple questions of the beginner. In the intensity of his search for new facts and new truths and the acquisition of new knowledge, he will just as surely neglect the novitiate, leaving him to his own devices, as he is to enjoy the discussion of doubtful points with his peers and stimulate them and be incited to renewed efforts.

I would not exclude the research man from graduate teaching or the teacher from all original productive work; but I do believe there should be separate provision for and a recognition of the difference between investigating and teaching. While in the present stage of development of medical education in Kansas we need teachers rather than investigators, as a matter of fact, men are being selected not because of pedagogical ability, but because of research powers or because of academic degrees. They are then expected to spend four or five hours daily in the class room, keep records

of class work and attendance, grade papers, attend to all details of material and equipment used and replacements needed, be their own bottle washers and handy man generally, in the laboratory, and in addition do some original research work that will reflect credit on the school. Such multifarious duties clog the mind and preclude the possibility of doing anything creditable in the way of research, unless something else is neglected. Too often it is the class that suffers and while he discourses on his hobby, he forgets that his class as a whole, are to become practical workers in medicine equally able to destroy inimical microbes, bring a new human being into the world, make the baby sneeze out a bean, pass a marble or cough up a dime.

Nowadays so much of the so-called research work is being done (or underdone), with so little purpose and without any particular aim that I am impelled to believe that the ideal medical faculty would be composed of doctors of medicine entirely—men who have had several years of actual experience. If a man be also a Ph. D., so much the better. And just here is where the Chancellor and the Board of Regents of the University have difficulty—in getting such men at the salaries the legislature permits them to pay. The medical failure is not wanted and the successful man is usually unwilling to cut his income to that of the average professor of chemistry or mathematics, who get too little as it is. The time will soon come as Barker has well said when "The professional class will be limited to bachelors, childless men, men enriched by inheritance or marriage or to married men who consent to doom their wives to the mitigated happiness that poverty affords."

Our public schools are already suffering from the withdrawal of the abler men and our state schools will be next. This finds application already in the scientific branches of the medical school and accounts for the number of non-medical men here. This is greatly to be depreciated as there is no doubt that all teachers of anatomy, physiology, pathology, bacteriology and public health work should be men of medical training with a medical viewpoint and medical tendencies.

While personal sacrifice and physical risk are taken by the profession as a matter of course and with no thought of aggrandizement or with the idea of great financial gain, this last is especially true of laboratory men and teachers, who, if they attain a notable discovery, give it freely to mankind for the advancement of civilization instead of claiming the financial reward that might justly be theirs. To such men, giving up the active years of their

lives for the good of humanity we should accord more honor and renown; provide more positions of preferment and make the emolument commensurate with the high value of their work.

With the clinician who gathers the fruits of the teachers and investigators, is somewhat different. People generally appreciate and more willingly reward the one whom they actually see doing things for them in the cure of disease and the relief of pain, than they do the man in the laboratory or classroom who makes these things possible. It is the clinician who makes use of and applies the knowledge learned by the anatomist, physiologist, pathologist and chemist who are delving deeper and deeper into the abstractions of these sciences out of sight and out of mind of the general public.

But, after all, who can say who is the more necessary, the man who discovers things or the one who wisely and properly uses them to promote the general welfare? Moreover, every physician is engaged in a piece of original research on every case he undertakes and did he only systematically and carefully record his findings, diagnosis and results, his complete work would be just as scientific as the monograph of the laboratory man and even more valuable to the profession.

Such records would be invaluable during the studies of the two clinical years when the student is applying to the cases under observation the abstract facts and truths learned in the first two. And later, when in independent practice, he would have not only his purely scientific knowledge, but the art and science of its application based on the successes and failures of his instructors.

In this connection I might say that because of the wonderfully rapid advancement recently made in laboratory diagnosis, the most valuable clinical methods of our forefathers are apt to be neglected. Many a young doctor can recognize the malarial plasmodium, who cannot outline the spleen; who can find a tubercle bacillus under the microscope, but cannot tell the friction rub of pleurisy from the movement of the skin under the stethoscope. My point is, that while we are teaching laboratory methods to good purpose, we should not fail to encourage clinical advancement or neglect the clinical knowledge we already possess, which has been tried and proven by years of practical test. It is just this which makes the old doctor better than the new. Sudden responsibilities do not confuse him, unexpected turns and new complications do not shake his confidence, grounded as it is in years of similar experiences.

The new methods and the accuracy and recognized value of

laboratory methods are, however, destroying the old empiricism and we are consequently using a more and more completely rational system of examination and treatment. The old-time narrow and bigoted conservatives who accepted blindly and belligerently, all empirical inheritances, denying contemptuously the value of all things new, interested more in a rigid code of ethics than in medical progress, believing nothing valuable that is not venerable, allowing their patients to be destroyed by precedent, rather than trying to save them by intelligent modern experiment—these men are dropping behind and filling the graves of failures.

After all, the physician's success depends more upon native ability and the thoroughness of preparation, and by preparation I do not mean the things he reads in books, sees in the dispensary or clinic or acquires in the laboratory, but as well, the cultivation of his faculty for studying patients, observing conditions and guaging human faults and frailties. He gets this in proportion as he is in close touch and sympathy with his instructors and observes their methods and actions in the presence of different individuals. Naturally he gets this mostly from the clinician who provides the example for the student in teaching him how to approach a patient, gain his confidence, draw out the facts skillfully, separate the essential from the trivial and arrive at correct conclusions. I would not encourage that fawning diplomacy shown by some in the presence of the rich or great, but plain understandable speech in order to satisfy the desire of intelligent people as to the reasons why. People worth considering are coming more and more to choose their medical advisors, because of his sound judgement and skill rather than because his wife is a good booster or wears a collection of stylish vegetables as headgear.

The clinical instructor, therefore, must have been a successful physician as well as a teacher and scientist to be of greatest value to the student. The tendency in our university and elsewhere is to prohibit medical instructors from engaging in competitive practice and confining him to hospital and consultation work, which is not competitive but which does bring him in contact with other doctors and with other than charity patients. To limit him to teaching alone as in the first two years would injure him and depreciate his value to the public.

Excellent as it is in most respects, I lose patience with the German method of placing the diagnosis above the patient and insisting that a diagnosis be made before treatment is begun even

if the patient goes to postmortem in the meantime. But this will not obtain in America where the average man with a stomach ache will insist on the relief of the symptoms first of all.

Therefore, the wise teacher will instruct his pupils to consider his patient and his feelings as well as the disease and the diagnosis. In this particular, our homeopathic brethern generally excels and often accounts for his larger practice in contrast to that of another better versed in laboratory technique.

My point is this, that a young doctor, no matter how purely scientific or finely theoretical, needs something more to be a success in the profession. He gets this indefinite something from the college environment, its general influence and atmosphere and by association and personal contact with the doctor who is in constant touch with patients and daily curing the sick. If that doctor be the sociable and cordial head of a department so much the better. At present in the overcrowded curriculum, there seems no place for such things nor any time to imbue the student with the knowledge that sly and illegitimate advertising is of no avail, that the division of fees and drug commissions are bad ,that lodge and contract practice are demoralizing and that all lead to evil results. He is left to learn these things by hard knocks in the bitter and ofttime humiliating school of experience.

Much that the student has been forced to learn from the primary grade on up through the high school, university and medical college, he could well, and perhaps, better do without. For instance in the grades he could dispense with much of the memory work in geography, history and practically all of trigonometry. In the university he is compelled to learn such a mass of philogic and etymologic facts in both the ancient and modern languages that when the time has come to leave, he can neither read readily or speak fluently a single one of them.

In medical school he is required to commit to memory the names, derivation, dose and action of hundreds of drugs, he will find of little value, even should he try to use them and weeks of time are spent in learning the chemistry, the preparation and the gross and microscopic appearance of plants without number—work belonging properly to the pharmacist—when if he learned quinine, strychnine, mercury, iron, iodine, morphine, arsenic and a half dozen others thoroughly and completely he would be better prepared. Osler very plainly says "that he who knows the worthlessness of most drugs is the best doctor." In bacteriology and pathology too, the study of the harmless yeasts and molds and of specimen after specimen of rare and incurable conditions and

degenerations might well be reserved for the post-graduate. In anatomy I cannot see the value of memorizing so many insignificant minuate forgotten before the end of the year, and never needed afterward.

In most schools surgery is the big department with the dominating clincis and an importance grossly exaggerated as far as the average medical student is concerned. Every student looks up to the surgeon as a major domo and anticipates the time when he can flourish his fascinating scalpel in a similar manner. As a matter of fact surgery is given much time that should be apportioned to internal medicine in the undergraduate years. Surgery is a specialty and as such should be placed with the others, but ranking first in importance. It really requires no more skill to remove a healthy appendix than it does to correct astigmatism, cure a gastric ulcer, properly and tactfully deliver a nervous woman, or prevent the spread of an epidemic.

If some of the unessential studies were omitted and the time apportioned to others in the curriculum cut down, there would be time for things of greater necessity to the medical student, and that, without increasing the hours of work or delaying the year of graduation. In the public schools by omitting some of the useless mathematics, more drawing could be given; instead of trigonometry, spend the time on biology and physics; instead of so much theory and philology in the dead languages, give the pupil a reading or speaking knowledge of French or German. This could be done and still send the boy to the university at 18 where, instead of requiring more Latin and Greek, quadratics and differential equations, he could take more physical culture for his bodies' sake or more botany, comparative anatomy and psychology. Psychology especially because we all know that power of suggestion which alters the frame of mind and the functions of the organs—a fact which has been taken advantage of by the christian scientists to our discredit.

By getting these preliminaries in the two college years he is ready for the medical course at 20. Then by cutting down the laboratory work he might be taught more of the causation and cure of organic diseases of the heart, brain and kidney. Instead of so much materia medica and pharmacy he might better have experimental pharmacology and instead of roosting on the rear row of an ampitheatre watching a surgical operation at long range with a pair of opera glasses he might use the time to better advantages acquiring a more thorough knowledge of natural therapeutics—the value of different baths, of exercise, rest, air,

sun and diet. In all departments his powers of systematic observation should be cultivated and more time given him to think over and digest his findings and to spend more time on the discussion of his conclusions and their correctness. He should be taught to weigh and judge symptoms and to measure their respective value.

Our present need in Kansas is for more good internests, and I am glad that the university has taken the lead to this end, by making internal medicine the department around which all the others are grouped. This is made possible because the Bell Hospital is entirely under the control of the university and all of the clinical and dispensary patients (of whom there are far more than its enemies would have you believe), are continuously available for scientific clinical teaching. Already five of the clinical staff in medicine, surgery, gynecology, obstetrics and pathology are on salary basis, so that complete and valuable records are being kept and the teaching done in a most thorough and scientific manner.

Last year, out of 341 Kansas medical students, Washburn kept only 46 and the university only 76, while 219 went elsewhere, mostly to Illinois and Pennsylvania. They took with them and and left about a quarter of a million dollars for fees and personal expenses. The gain of Chicago, Philadelphia and St. Louis is the loss of Washburn, the University and the State. A sum more than sufficient to maintain abundantly both medical schools. If the legislature granted the university only one tenth of this amount for the establishment of a department of hygiene and public health and put a doctor of medicine in charge it would keep in the state and return to the people ten-fold its cost by the prevention of disease. Physicians could more easily have analyses of sputum, tissues, water and milk made at little or no cost and the causes of disease and epidemics could be investigated and quickly checked in connection with the board of health. The value of the university, of the board of health, and of the regular medical profession as a means of preventing disease and epidemics could thus be brought home to the people. Physicians as a rule, are too modest in telling the people of their part in this matter, and when they do they are often misunderstood.

Most of our Kansas students will naturally return here and become co-workers with us. How pleasant or how disagreeable that association will be depends upon ourselves. The profession of this state, particularly the members of this society, have it within their power to keep our students within our borders and

to say what the nature and the plan of their education shall be. Do you wish broad, high minded, well prepared co-workers—men above financial bickerings and petty jealousies? Then interest yourselves in the medical schools of our state. Use your influence that the state provide more liberally for our own school, not only as a matter of state pride, but as a matter of economy. Then you will make possible the employment of medical men, giving their whole time to medical students and Kansas men will not be forced to go elsewhere for their medical education.

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The contraindications to the use of arsenobenzol are: advanced syphilitic myocarditis; advanced syphilitic disease of the aorta or coronary arteries, or aneurysm; syphilitic aortic insufficiency; hemiplegia from ruptured syphilitic artery; advanced general paresis; advanced disseminated sclerosis; advanced tabes dorsalis; extreme debility or emaciation.

——o——

Atypical Mastoiditis.—The most characteristic sign in cases of atypical mastoiditis, says E. B. Dench, New York (Interstate Medical Journal, November), is the appearance of the fundus of the canal. A pronounced sinking of the upper and posterior wall of the external canal is quite constantly present, and in a number of cases, occurring in late adult life, this one sign was the chief evidence of mastoiditis. Impairment of hearing persisting for two months or longer after an acute otitis is a strong confirmative sign of mastoid trouble. A persisting profuse otorrhea, resisting irrigation and free incision always means mastoid involvement and is sometimes the chief evidence of such involvement. An apparently spontaneous perforation on the posterior wall of the external auditory canal, simulating furunculosis, has been observed three times by the writer in the past half year. The X-ray sometimes gives great help in these doubtful cases. More experience will be necessary before this measure can be of absolute diagnostic value, but it very often proves useful.

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A gangrenous gall-bladder mucosa is usually easily stripped out (Mayo). It is quicker proceeding that cholecystectomy, and provides more rapid healing than mere cholecystostomy.

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Hemorrhage from an old, indurated gastric ulcer is a much more serious matter than bleeding from a more recent ulcer, since in the former the vessel may be unable to collapse and allow clotting.—American Journal Surgery.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, J. E. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft, Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr, H. G Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian, S. G. Stewart, Topeka.

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EDITORIAL

The proceedings of the last annual meeting, which should have been published in this issue, will not appear until July. This is due to the fact that the stenographer's report was not ready.

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The American Medical Directory recently issued, is as complete as it is possible to make it. It contains reliable information concerning 147,000 physicians in the United States, its dependencies and Canada. The various ramifications which it is necessary to follow to complete a directory of physicians, requires a large number of employees, whose sole duty is to investigate every one with a title of M. D. The A. M. A. has a complete file of the graduates of every medical college, the registration (in recent years), from every state board of medical registration and much other data which will in time make it practically impossible for any one to practice medicine in this country without the A. M. A. knowing it. The directory is a great credit to the publishers.

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County Secretaries—Notice.—The councillor of your district is now an associate editor of the Journal. He has taken the task to collect all items of interest to the profession, viz., medical meetings, changes of address, marriages, births, deaths, etc., in his dis-

trict. Now you will please send him a report of every medical meeting and every happening of interest in your county. Blanks will shortly be furnished which will facilitate the making of the reports. Now if there is nothing in the Journal from your county remember the fault will be with the secretary. The twelve councillor districts comprise the following counties:

LIST OF OFFICERS OF COUNTY SOCIETIES.

FIRST DISTRICT.

C. W. Reynolds, Councillor, Holton, Kansas.

COUNTY	PRESIDENT	SECRETARY
Nemaha	W. G. Boise, Centralia	N. Hayes, Seneca.
Brown	J. O. Ward, Horton	H. J. Harker, Horton.
Doniphan	A. D. Hobson, White Cloud	H. G. Herring, Sparks.
Jackson	J. W. Darlington, Dennison	Chas. M. Seiver, Holton.
Atchison		W. F. Smith, Atchison.
Jefferson	A. D. Lowry, Valley Falls	F. P. Mann, Valley Falls.
Marshall		B. P. Hatch, Beattie.
Washington		W. M. Earnest, Wash.

SECOND DISTRICT.

C. C. Goddard, Councillor, Leavenworth, Kansas.

Leavenworth	C. E. Brown, Leavenworth	J. L. Everhardy, same.
Wyandotte	Geo. M. Gray. Kans. City	J. F. Hassig, Kans. City.
Johnson	T. S. Greer, Edgerton	F. F. Green, Olathe.
Douglas	S. T. Gillespie, Lawrence	Leon Matassarin, same.
Osage		J. J. Murphy, Osage City.
Franklin	J. B. Davis, Ottawa	W. L. Jacobus, Ottawa.
Miami	J. N. Hill, Osawatomie	J. D. Walthall, Paola.
Coffey		
Anderson	Albert Settle, Harris	T. D. Blasdel, Garnett.
Linn		H. L. Clark, LaCygne.

THIRD DISTRICT.

H. B. Caffey, Councillor, Pittsburg, Kansas.

Woodson	H. W. West, Yates Center	E. K. Kellenberger, Y. C.
Allen	A. J. Fulton, Iola	O. L. Cox, Iola.
Bourbon	E. B. Payne, Ft. Scott	R. J. Whitfield, Ft. Scott.
Wilson	B. R. Riley, Benedict	E. C. Duncan, Fredonia.
Neosho	P. Follette, Chanute	A. M. Davis, Erie.
Crawford		H. B. Caffey, Pittsburg.
Montgomery	W. S. Hudiberg, Indepen.	J. W. Pinkston, Indepen.
Labette	C. N. Petty, Altamont	O. S. Hubbard, Parsons.
Cherokee	R. C. Lowdermilk, Galena	A. A. Shelley, Galena.

FOURTH DISTRICT.

W. E. McVey, Councillor, Topeka, Kansas.

Clay	G. A. Tull, Clay Center	G. W. Bale, Clay Center.
Riley		C. R. Hepler, Manhattan.
Pottawatomie		
Wabaunsee		J. N. Kemper, Alma.
Geary	W. A. Carr, Junction City.	W. A. Smith, Junc. City.
Dickinson		W. A. Klingburg, Elmo.
Lyon	J. F. Worley, Emporia	B. E. Garrison, Emporia.
Shawnee	S. A. Johnson, Topeka	C. E. Joss, Topeka.

FIFTH DISTRICT.

W. E. Currie, Councillor, Sterling, Kansas.

Barton	G. O. Speirs, Ellinwood	M. T. Russell, Grt. Bend.
Rice	L. E. Vermillion, Lyons	J. M. Little, Sterling.
Marion		J. A. Haake, Peabody.
Chase		C. L. Conaway, Ctt'n Fls.
Greenwood	J. Dillon, Eureka	S. F. McDonald, Climax.
Butler	F. A. Garvin, Augusta	R. B. Earp, Eldorado.
Harvey	R. S. Haury, Newton	F. L. Abbey, Newton.
Reno	C. Klipple, Hutchinson	W. F. Schoor, Hutch.
Stafford	J. T. Scott, St. John	Cyrus Wesley, Stafford.

SIXTH DISTRICT.

Arch D. Jones, Councillor, Wichita, Kansas.

Pratt	H. Atkins, Pratt	R. E. Anthony, Pratt.
Kingman		J. M. McKamey, King'n.
Elk		F. L. DePew, Howard.
Chautauqua	J. S. Vermillion, Sedan	W. L. McNaughton, Sd'n.
Cowley	L. A. Jacobus, Winfield	C. R. Spain, Ark. City.
Sumner	E. Trekel, Milan	T. H. Jamieson, Well'g.
Barber	R. W. Coffey, Hardtner	G. R. Waite, Kiowa.
Sedgwick	W. A Phares, Wichita	John Hagan, Wichita.

SEVENTH DISTRICT.

W. F. Sawhill, Councillor, Concordia, Kansas.

Harper		
Rooks		
Osborne		H. W. Nye, Osborne.
Jewell		
Mitchell	R. G. Nelson, Glen Elder	K. P. Mason, Cawker Cy.
Republic	J. B. Henry, Scandia	J. C. Decker, Belleville.
Cloud	F. A. McDonald, Concordia	E. N. Robertson, same

EIGHTH DISTRICT.

O. D Walker, Councillor, Salina, Kansas.

Lincoln		

Ottawa.....
Saline.....J. W. Neptune, Salina.....O. D. Walker, Salina.
Central Kans.C. D. Blake, Ellis.....E. A. Bowles, Ellsworth.

NINTH DISTRICT.

C. S. Kenney, Councillor, Norton, Kansas.

Rawlins and..
Cheyenne.....H. H. Johnson, Atwood....W. C. McIrvin, Atwood.
Norton and...
Decatur..... C. S. Kenney, Norton.
Phillips.....
Smith.....V. E. Watts, Bellaire.....F. H. Relihan, Smith C'r.

TENTH DISTRICT.

E. J. Beckner, Councillor, Seldon, Kansas.

Tri-County...D. R. Stoner, Quinter.....E. D. Beckner, Hoxie.
Western Kan. F. A. Carmichael, Good.

ELEVENTH DISTRICT.

J. A. Dillon, Councillor, Larned, Kansas.

Pawnee.....V. O. Standish, Larned....A. E. Reed, Larned.
Edwards.....

TWELFTH DISTRICT.

W. F. Fee, Councillor, Meade, Kansas.

Clark and....
Commanche..G. M. Kendall, Englewood..F. I. Dodge, Ashland.
Meade and....
Seward.....G. S. Smith, Liberal.....T. L. Higginbotham, Liberal.
Kiowa.....J. A. Gardner, Greensburg H. J. Willey, same.

Remainder of Counties in state not organized.

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It is well for medical societies to look up the professional standing of anyone, physician or layman who may volunteer to present a paper or address before their body. Embarassing situations may thus be avoided. The Nemaha county medical society at a meeting held at Sabetha, recently was addressed by "Prof." Weltmer of Nevada, Mo., on some subject of mental healing. This gentleman is not a graduate physician and belongs to the crowd of mental healers whom the Government saw fit to put out of business some years ago for misuse of the mails. "Prof." Weltmer has sent letters volunteering to present an address, to many of the county societies of the state, the one to the Wyandotte County Society being ordered into the waste basket.

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The annual celebration of Independence day is near at hand and we as medical men are derelict in our duty if we sit idly by

without trying to get municipalities to pass stringent laws looking toward a "sane fourth". The annual roster of the dead from celebrations is becoming less and less, principally from the restriction placed upon the use of fire-arms. But the number should dwindle to nothing and it will be so if proper measures are enforced. Of course the modern methods of treating gun shot wounds and the treatment of tetanus with antitoxine has lessened the mortality from 4th of July injuries, but the real preventative is to prevent the accidents and they can be prevented with proper legislation rigidly enforced.

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Ophthalmia Neonatorum.—Laws for the prevention of the blindness of new-born infants are making progress slowly. Many of the states have recognized the need of measures to prevent the disease. Some states have issued instructions regarding the proper methods of prophylaxis and some also furnish packets containing preparations of silver salts for use in the eyes of the new-born. The records of institutions for the blind show that from 23 to 35 per cent of the inmates have become blind as a result of ophthalmia neonatorum. Among the states in which the disease is notifiable are Connecticut, Massachusetts, Minnesota, Nebraska, New York, Oregon, South Carolina, Utah, Vermont and Wisconsin. In some states a nurse, midwife or parent is required to report the disease. In most cases, at least, the disease can be prevented and where it exists proper treatment will, in many instances, prevent loss of vision.—Pub. Health Rep.

It is time we of Kansas should be at work to prevent and cure this disease which is responsible for so much blindness. In the first place we should have a law making compulsory notification of ophthalmia neonatorum. Then we should carry on a vigorous campaign of education embodying the proper methods of prophylaxis. Every midwife should be instructed as to its prevention and pamphlets should be distributed to all the laity explaining the seriousness of the disease and the comparatively easy method of its prevention. The number of cases of ophthalmia neonatorum is not near as great now as heretofore, but far too many. There should be NONE.

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A TEST FOR KANSAS HEALERS.

By A Supreme Court Decision an Examination Is Necessary to Practice.

TOPEKA, May 11.—The Kansas Supreme Court in a deci-

sion handed down today, held that chiropractors and practitioners of suggestive therapeutics and other healers who profess to cure sick and diseased people must pass an examination and obtain a certificate from the state board of medical registration and examination.

J. N. Peters of Smith County was convicted of practicing medicine without a license. The supreme court held, in affirming his conviction, that anyone who "professed to treat sick and diseased people, maintained an office for that purpose and treated patients for the cure and relief of bodily infirmities or diseases, by examination of the person and by rubbing the parts of the body supposed to be affected, doing this as a business for fees," is subject to the law requiring examination. The court further held that the exemption in the law creating the board of medical examination so that it would not interfere with religious belief does not apply to those who practice medicine by rubbing the body and accepting fees.—K. C. Star.

This is a valuable decision to the medical profession of Kansas. With it we should not harbor any more of this cult in our locality.

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SOCIETY NOTES.

PROGRAM HARVEY COUNTY MEDICAL SOCIETY, FOR JUNE.

LABOR.

"When and How to Use Forceps." Dr. R. C. McClymonds. Discussion, Dr. F. L. Abbey.

"Diagnosis of Position and Presentation." Dr. L. T. Smith. Discussion, Dr. J. T. Axtell.

"Asepsis and Antisepsis." Dr. J. M. Sutton. Discussion, Dr. S. S. Haury.

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The medical Association of the Southwest will meet at Hot Springs, Arkansas, October, 1912.

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The Wyandotte County Medical Society has adjourned for the summer. At the last meeting held May 21, the following program was given:

Report of a Case of Fibroid of Uterus with presentation of Specimen, Dr. R. C. Lowman.

Version, With Report of Case, Dr. E. A. Reeves.

Report of a Case of Dystocia from Rachitic Pelvis, with Caesarean Section, Dr. W. S. Sutton.

Library and Laboratory Facilities of the Kansas University

and Their Relation to the profession of Wyandotte County, Dr. M. T. Sudler.

Forty members were in attendance and the meeting was a lively one. The society is in better condition than ever in its history, having more than ninety members paid up.

J. F. HASSIG, Sec'y.

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The medical profession of Ottawa, Saline and Lincoln Counties held a joint meeting at Minneapolis, Thursday, May 23, at 8 o'clock p. m. This meeting was arranged by the Saline County Medical Society. Papers were read by Dr. Brewer of Minneapolis, subject "Care of the Pregnant and Lying-in Woman" and Dr. J. K. Harvey, Salina, subject "Etiology and Treatment of Empyema. The papers were carefully prepared, were well received and fully discussed.

Two visiting clergymen, Rev. Snowden of Minneapolis and Rev. Mayo of Sylvan Grove, were called upon and spoke of the 'Duties of the Medical Profession to the Public.' Prof. Willard of Manhattan was also present and spoke of 'Reciprocial Relations of Laity and Medical Profession'.

The meeting was well attended and all present felt fully repaid for the time and effort spent in coming

Other meetings similar in character are planned for the future. The profession of the three counties expecting to meet in this way four times during the year.

Physicians present were: Drs. Brewer, Cludas, Kilbourne and Harvey of Minneapolis; Dr. Dierker, Sylvan Grove; Dr. Vermillion, Tescott; Dr. Graf, Assaria; Dr. Cheney, Gypsum; Dr. Towsend, Barnard; Drs. Neptune, Simmons, Crawford, Brittian, Anderson, Simpson, Moses, J. K. Harvey, Dr. Lutz and Walker of Salina.

Visitors: Prof. Willard, Manhattan; Rev. Snowden, Minnea polis; Rev. Mayo, Sylvan Grove; and Dr. Coulter, dentist of Minneapolis.

O. D. WALKER, Secretary.

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NEWS OF THE THIRD DISTRICT, DR. H. B. CAFFEY, Councillor.

Dr. H. C. Markham of Parsons, is now in Chicago taking postgraduate work, preparatory to doing eye, ear, nose and throat work as a specialty.

Dr. M. L. Perry of Parsons, to left the last of May to attend the meeting of the Medico-Psychological Association andthe A. M. A., in Atlantic City.

Dr. Mary V. Church of Topeka has recently located in Pittsburg being associated with Dr. Frances A. Harper.

Drs. H. L. Stelle and W. H. Graves have just returned from a two weeks visit to the Chicago clinics.

Dr. D. O. Monson of Franklin, has located in Pittsburg and will confine his practice to the specialty of eye, ear, nose and throat.

The Montgomery County Medical Society has decided to hold no more meetings until the heated season is past. They will have the next meeting in September.

Dr. John J. Sippy of the state board of health is in Pittsburg this week making inspections of local health conditions and incidentally jacking the doctors up for not making the required reports of births and deaths. Surely it is a deplorable state of affairs when a law, which all physicians know to be a good one has been put on the statutes, and the physicians themselves become the violators.

Dr. F. M. Wiley was called to Albany, Oregon on May 1st on account of the serious illness of his brother-in-law, J. D. Allen.

The following physicians in Wilson County are running new autos: Dr. A. P. Williams, Neodesha; Dr. B. R. Riley, Benedict and Dr. E. C. Duncan, Fredonia.

Dr. A. N. Grey has recently located at Altoona and has been appointed City Health Officer.

Dr. J. L. Moorehead of Neodesha has been quite active in politics lately.

One of our "irregulars", Dr. L. R. Chapman who until recently ran a cure-any-old-thing-with-out-the-knife-so-called sanatarium, at Fredonia, was convicted of abandoning his wife under the new law which makes it a penitentiary offense.

Dr. B. R. Riley was in Kansas City May 13th to 16th, on business, and attended the Grand Commandry.

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The Nemaha county medical society met at Sabetha, Kansas, May 23. The society met at Dr. S. Murdock, Jr's. hospital.

In the afternoon Dr. Murdock held a surgical clinic for the visiting doctors. In the evening the society was called to order by the president, Dr. W. G. Barnes. Dr. J. A. Maetews read a paper on "Some Rare Causes of Death in the New Born." Dr. N. A. Haynes presented an exhaustive paper on "General Anesthesia." The society was addressed by "Prof." S. A. Weltmore The next meeting will be held at Wetmore, July 25th at 2 p. m.

NOAH HAYES, Sec'y.

NEWS NOTES

Dr. Albert N. Gray of Altoona, Kansas and Miss Cora M. Baker of Palasades, Colorado, were recently united in marriage.

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Dr. Gilbert C. McCormick and Miss Pearle V. Neafus of Wichita, were united in marriage, May 8.

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Dr. W. S. McDonald of Fort Scott, was recently elected president of the Frisco System Medical Association.

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Dr. W. F. Schoor has been appointed city physician of Hutchinson, vice Dr. J. W. Young.

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Dr. W. E. Regier of Harper has assumed charge of the Updegraff Hospital at Anthony.

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Dr. J. C. Montgomery has been re-appointed health officer of Riley County.

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Dr. J. B. Gardner of Pittsburg, has been appointed physician of Crawford county, vice, Dr. C. C. Fisher, resigned.

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OBITUARY,

Thomas Marcus Warnock, M. D., College of Physicians and Surgeons, Keokuk, Ia., 1884; formerly a practitioner of Tunnel Hill, Ill., and Liberty, Neb., who retired from practice and moved to Superior, Neb., and later to Sterling, Kan; died suddenly, April 10, aged 60.

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Charles L. Conaway, M. D., Iowa Medical College, (Electic) Des Moines, 1883; a member of the American Medical Association and secretary of the Chase County (Kan.) Medical Society; local surgeon of the Santa Fe Sytsem; died at his home in Cottonwood Falls, April 29, aged 52.

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Robert H. Truesdale (license, Kansas, 1901); a practitioner of Pardee, Doniphan and Kirwin since 1862; died at a hospital in Downs, April 8, from disease of the kidney, aged about 70.

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Edward D. Thomas, M. D., Starling Medical College, Columbus, O., 1874; died at his home in Garnett, Kan., March 12, from tuberculosis, aged 66.

Royal McShea (license, Kansas, 1901); for thirty-five years a practitioner; died at his home in Chapman, April 7, aged 73.

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MISCELLANEOUS

For Sale.—1 X-ray coil, Scheidel; 1 rheostat, (wall-plate); 1 high frequency apparatus; 1 tube stand.—Mrs. John Troutman, 902 N. 7th St., Kansas City, Kansas.

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Medicine, sometimes impertinently, often ignorantly, often carelessly, called "allopathy," appropriates everything from every source that can be of the slightest use to anybody who is ailing in any way, or likely to be ailing from any cause. It learned from a monk how to use antimony, from a jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmatser how to sound the eustachian tube, from a dairy maid how to prevent smallpox, and from an old market-woman how to catch the itch insect. It borrowed acu-puncture from the Japanese, and was taught the use of lobelia by the American savage. It stands ready to-day to accept anything from any theorist, from any empiric who can make out a good case for his discovery or his rememedy.—Dr. Holmes.

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For Sale.—Static Machine, resonator, wall plate, 500 C. P. leucodescent lamp, neublizer, victor vibrator, miscrocope, Yale chair.—Gertrude Barnes, Administratrix.

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Professor Samuels.—Readers of The Journal have heard of "Professor" Samuels, the quack who has made millions by selling a weak watery solution of sugar and salt at $5 an ounce. Until recently, Samuels made his headquarters at Wichita, Kansas. The Journal exposed his nefarious trade and asked editorially, "What's the Matter with Kansas?" that it should tolerate a fraud like Samuels. Kansas answered the question by making the state too hot for the quack. As a result, Samuels advertised that he was going to move to Detroit, Mich., so as to be located "nearer the center of the United States," thus indicating that he believed the public's ignorance of geography to be equal to its gullibility. He had barely got settled in his Detroit offices when The Journal called attention to the fact and asked "What's the Matter with Michigan?" An answer was again forthcoming in no uncertain tones, when the public prosecutor raided Samuels' offices a week

ago, arrested the "professor," seized his card-index of victims and carried off a barrel of sugar and a bin of salt. When arrested, the faker declared that he left Kansas because the climate of that state did not agree with his wife's health. It would probably be nearer the truth to say that he left Kansas for his own health. Every man who has the interest of the public at heart will congratulate the Detroit authorities if they succeed in making that city as unhealthful a place for Samuels to live in as Wichita has been made. —Journal A. M. A.

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During the month of April a law was signed by President Taft that eliminates "phossy jaw" from the list of industrial diseases that are without governmental attention. At last the United States is in a position of equality with the various countries who in earlier years signed an international treaty prohibiting the use of white sulphur in the manufacture of matches. Only by means of taxation was it possible to eliminate the poisonous phosphorus from the commercial field. The present law prohibits the importation of the poisonous type of matches and places a prohibitive tax upon their manufacture in this country.

The patent for the manufacture of matches with the harmless sesqui-sulphide was cancelled by the Diamond Match Company at the request of President Taft. Although it took one year to secure the proper amount of enthusiasm and public sentiment to offset the increased commercial cost in the production of the harmless type of matches, battle was constantly waged and the lives and jaws of many workers have been at last protected.—American Journal Surgery.

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The Thirty-Call-A-Day Doctor.—Dr. Cabot, in a recent address, remarks that one day, while riding along in the buggy of an old-time country practitoiner, he asked him: "Why do we no longer hear of the tremendous practices formerly supposed to have been possessed by some men, who it is said, often over considerable periods of time, made their thirty and forty calls a day?" It was the older doctor's opinion that the laity has awakened to the fact that the doctor who is too busy has neither the time or inclination to devote the necessary amount of attention to the individual case. Hence, there is now, more than there was formerly, a stronger tendency toward an equalization of the amount of work the physician finds to do. The average patient is no longer content, and rightly so, with the perfunctory grasp of the wrist, glance at the tongue, one question about the appetite,

another about the bowels, and then the hastily written prescription. It was formerly supposed by the young and struggling physician that whether he was busy or not, it was necessary to appear busy. In other words, the less busy he was the more busy he had to be keeping up an appearance of being busy. This may still in some degrees be true, but there is now a limit such as there did not seem to be formerly, when people were glad to wait half a day for the privilege of being given two and one-half minutes' attention by some famous but overly busy doctor. It is well for us to keep the golden rule in mind, and when we reach that literally golden era of practice where we are so busy that we cannot give the patient that sincere, detailed, and conscientious attention that we ourselves would wish to have given us were we in the possition of the patient, to refer those patients to the younger man, who can afford to give them a sincerer attention and inject into the treatment of their case a fresher enthusiasm.—The Lancet-Clinic.

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The Worry Habit.—How many physicians daily meet patients whose chief ailment comes from the habit they have of worrying over their troubles? It may be that their troubles are large; if not large, then small ones appear large. We all of us know optimistic individuals who have troubles of the major kind, but they possess sunny dispositions and brush away their cares with ease. Others manufacture troubles, if there is no other way of securing them, and sleepless nights and a general disposition to worry is the result. The physician who can successfully cultivate the habit of being sunny himself, and can get his patients to look on the bright side, rather than the dull side of things, will always possess a valuable asset.—Medical Summary.

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Medical Witness Cannot be Cross-Examined as to Medical Authorities for Purposes of Contradiction.——In an accident case a physician, testifying for the plaintiff testified that he found symptoms of spinal injury and as a foundation for his opinion that such an injury had been sustained said that he had found an anesthetic area about the lower portion of the spinal column, more pronounced on the right than on the left side. On cross-examination he expressly declared that he had never heard or read of a case, where paralysis of spinal origin was on one side only. He was further asked if every authority did not state

that paralysis of spinal origin must exist on both sides. Objection to this question was sustained. Examination of an expert medical witness as to the contents of medical works is permissible only when the witness has based his opinion wholly or partially upon his reading of such books; and then only when statements therein are not in harmony with the testimony of the witness. In this instance an affirmative answer would not have contradicted the testimony of the witness. (Griffith vs. Los Angeles Pac. Co. Co., California Court of Appeals, III Pac. 107.)—Journal of the New Jersey Medical Society.

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CLINICAL NOTES

Syphilis, Diabetes and Salvarsan.—J. Rhodes Longley, Fond du Lac, Wis. (Journal A. M. A., April 20), reports the case of a man who came to him Nov. 7, 1911, complaining of some peculiar cerebral seizures attended by dizziness, transitory aphasia and general weakness. Their exact nature was not clear. In the course of the examination there was revealed a sore on the penis which had ulcerated almost through the frenum. There was very little induration, and in ten days with soaking in warm boric-acid solution it readily healed . December 5, the patient began complaining of slight sore throat and a papular rash was present over the abdoman. On the 15th he returned with a general papular rash and other more marked symptoms of syphilis. Longley prescribed a suitable diet for him and told him of the salvarsan treatment for syphilis, which he was anxious to try, for the two diseases were, he believed, too much for him to contend with mentally. Salvarsan was injected intramuscularly, with the usual care as to asepsis. The patient suffered practically no pain and rested well that night. Pulse was slightly increased, and December 23, he went home with the rash almost gone. While the safety of salvarsan in all cases of syphilis occuring in diabetes is not proved by the experience with one patient, it is interesting to note that in this instance, at least, no harm followed its use.

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Treatment of Damaged Intestine Without Resection.—H. B. Angus notes that frequently when doing emergency work one meets with an intestine which is torn, gangrenous, perforated over a limited area; or, after separating adhesions, free oozing is so persistent as to necessitate immediate treatment. In many cases of this kind resection appears to be the only recourse, but if the pa-

tient is old and feeble, exhausted, or suffering from severe shock time is an important consideration, and the following simple method will be found most useful; Where there is a perforation—for example, from a bullet wound—a suture or two of chromicized catgut passing through all the coats approximates the edges of the rent; then with Pagenstecher's thread the adjacent sides of the damaged area of intestine are brought together by means of a Lembert suture—either continuous or interrupted—thus enclosing the weak spot. At first sight it appears as though obstruction would result from the kinking of the bowel, but this complication has not ensued after repeated trials. The method is simple, and occupies a short time as compared with resection and subsequent anastomosis.—Medical Record.

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When the abdomen is opened to discover the sigmoid, if it is not found at once, search should be made toward the median line.

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If rectal examination in a case of intraabdominal carcinoma reveals in the cul-de-sac the infiltration known as "Blumer's shelf" metastasis has developed and radical operation cannot be undertaken.

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An amebic colitis that has been quiescent frequently lights up after a complicating liver abscess has been drained. Such patie ts may recover from the abscess and succumb to the colitis. In all cases of amebic liver abscess, therefore, treat the bowel also, by appendicostomy and irrigation, even though it is giving no symp toms.—Surgical Suggestions From American Journal of S rgery.

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Suggestion in Hopeless Disease.—Through fostering and strengthening that power (to master disordered feelings) in his patients who are hopelessly sick, the physician can best demonstrate his powers for good. As Billroth said in a speech delivered in 1891, "The patient comes to the physician for advice, consolation and hope; if you give him nothing of this, you may be an excellent diagnostician and prognosticator, but you are no doctor." —Jacoby in "Suggestion and Psychotherapy."

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If blood is vomited in large quantity it is important to distinguish, by the history and physical signs, between gastric ulcer and ruptured varicosities of the esophagus.

Pleurisy—Treatment of. The treatment of acute pleurisy requires but little observation; however, it is sometimes useful to take a hurried glance at the methodic treatment by such an authority as Professor Robin, of Paris, as described in the Medical Press and Circular, October 18, 1911.

The patient being put on exclusive milk diet, a laxative and diuretic dose of calomel is given: calomel, 8 gr., divided into four packets, one every hour.

The following day ten grains of salicylate of soda are given every six hours. Jaborandi has been employed in infusion (1 dr.) taken during the day to excite salivation and sudation, but it is a dangerous remedy, and should never be employed, at least in pleurisy of the left side.

The blister has been impugned by many as being dangerous, oppressing the nervous system, provoking congestion of the kidneys, irritating the bladder, provoking fever and exposing to infection, sometimes mortal. To these objections Professor Robin replies that the blister increases phagocytosis, and increases pulmonary ventilation in the proportion of 50 per cent. The patient consumes 25 per cent more of oxygen. It has only a revulsive effect, but a dynamic action on the respiratory changes.

Therefore, toward the sixth or seventh day, when the temperature beings to go down and the effusion remains stationary, a large blister should be applied. The blister diminshes the dyspnea, and far from raising the temperature, it lowers it after a slight transitory elevation. The blister should be powdered with camphor, and the skin well washed with soap, and afterward with alcohol and ether at the point of application. It should never be placed right on the back on account of irritation and the difficulties of dressing; it is applied to the side and left ten hours in situ.

If, after that time, the skin is only reddened, a poultice of starch is applied to produce the desired "blister"; boric acid ointment completes the after dressing. Blisters should not be prescribed in persons suffering from Bright's disease or hypertrophy of the prostate.

Besides the above fundamental treatment, certain symptoms require attention. The pain in the side may need an injection of morphine; great dyspnea, an injection of one-tenth of a grain of chlorohydrate of heroin. In case of a persistent hyperthermia, M. Robin recommends the association of pyramidon (6 gr.) and hydrochlorate of quinine (8 to 12 gr.), the quinine to be given ten minutes after the pyramidon.—Journal of the Medical Society of New Jersey.

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THE TREATMENT OF CANCER OF THE CERVIX.

DR. G. M. GRAY, Kansas City, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

As the ureters in the female are always in great danger of injury in radical operations for cancer of the cervix and as recurrences take place both by continuity of tissue and through the lymphatics, I desire to briefly go over the anatomy of the parts concerned in radical operations before entering upon the considerations of the treatment for cancer of the cervix and will begin by first taking up the relation of the ureter to the uterus and cervix.

The blood supply of the uterus and the lymphatics.

The ureter in the female.

The pelvic portion of the ureter in the female is about four inches long. It crosses the pelvic brim at a level with the first piece of the sacrum and passes over either the common iliac artery at its bifurcation or the external iliac at its commencement. It then follows the wall of the pelvis downward just posterior to the ovary, and near the floor of the pelvis, bends forward to pass through the base of the broad ligament. Traversing the loose, connective tissue (parametrium) and being about one-half to three-fourths of an inch outside of the cervix. At that point it is crossed by the uterine artery. It then inclines somewhat inward and forward along the sides and anterior wall of the vagina to enter the bladder. Its opening into the bladder is about one inch below the level of the external os which is almost as far down as the middle of the anterior vaginal wall. The ureters run in the bladder wall obliquely for about three-fourths of an inch, and their openings are from one to two inches apart, according to the amount of vesical distention.

Blood Supply of the Uterus.—The main blood vessels of the pelvic genital organs are the uterine and ovarian arteries, described

by some authors as the single uteral ovarian artery. The uterine artery comes from the internal iliac and passes almost horizontally inward toward the lower portion of the cervix. As it approaches the cervix it gives off a cervico vaginal branch which passes to the upper part of the vagina. At this point it has just crossed in front of the ureter and is about on a level with the external os. It then inclines upward, reaching the sides of the uterus at its junction with the vagina. It passes the side of the uterus in nullipara a short distance away from its sides, but in multipara close to it, until it reaches the cornu above.

It here is continuous with the ovarian artery. The ovarian artery comes down from the aorta, as does the spermatic artery in the male. It crosses the brim of the pelvis in front of the ureter, enters the infundibulo-pelvic or suspensory ligament of the ovary, and runs horizontally towards the uterus in the broad ligament between the round ligament and the ovary. As it reaches the cornu of the uterus it crosses in front of the round ligament and joins the uterine artery. As the uterine and ovarian arteries are continuous with each other, either one may be the larger, and they vary considerably in size.

A branch of the deep epigastric artery accompanies the round ligament inward and anastomoses with the uterine and ovarian arteries.

Lymphatics.—The cervix has three sets of lymphatics. The first set passes outward and upward along the side of the pelvis, anterior to the ureter to empty into the nodes along the external iliac artery. The second set passes backward behind the ureter to empty into a node on the anterior division of the internal iliac artery. The third set passes from the posterior surface of the cervix almost directly backward in the uterosacral ligament to empty some into the lateral sacral nodes high up in the hollow of the sacrum, and some into the node of the promontory, The lymphatics of the body of the uterus communicate with those of the cervix below, and at the cornu pass out as four or five trunks along the broad ligaments between the ovary and fallopian tube, being joined by branches from the ovary and emptying into the aortic nodes just below the kidneys. Also a lymphatic generally accompanies the round ligament from the cornu of iliac uterus to empty into the inguinal nodes.

Cancer of the Cervix.—Naturally, cancer of the uterus divides itself into cancer of the cervix and cancer of the body, or fundus of the uterus—as the behavior in way of extension is quite different in cases of cervical cancer and in cancer of the body of the uterus.

Dr. Peterson, of Ann Arbor, Michigan, in an article in the January Number of Surgery, Gynecology and Obstetrics, on the radical abdominal operation for cancer of the uterus, says "As far as possible cases of cancer of the cervix should be considered separately from those where the body of the uterus is the seat of the disease. This is because of the tendency of carcinoma of the body to limit itself for some time to the uterus. The broad ligaments and pelvic glands are involved in this type of the disease very much later than is the case in cancer of the cervix. Hence, one will see cases of cancer of the body earlier than where the cervix is the seat of the disease, and the result obtained from operation will be much better, as extension and metastases does not occur outside of the uterine body early as in cancer of the cervix.

My intention is to deal only with cancer of the cervix, which is five to ten times more frequent than cancer of the body, and the results obtained by any treatment at the present time most unsatisfactory, owing largely to the late diagnosis. Early extension into parametrium and pelvic lymphatic glands. Berkley states that examinations in 107 patients dying from cancer ofthe cervix at the Middlesex Hospital, show that in 25.2% secondary deposits were entirely limited to the lumbar glands. In 30.3% both glands and viscera were involved. He concludes that in at least one-thrid of the patients who come to the surgeon for operation, some of the pelvic glands are already infected. Wertheim found that in 10% of the cases, notwithstanding the absence of cancer in the parametrium, the lymphatic glands were cancerous, while in 27.5%, although the parametrium was infected, the glands were free. In 40% he found the parametrium and lymphatic glands free from cancer, and in 20% both were infected.

Opitz found the glands diseased in 33%, and Pankow in 38%. Ries claims that the reason that more glands are not found infected with cancer is due to faulty technic as many serial sections are required before cancer cells are discovered. Most of these opinions are from men who undoubtedly see these cases much earlier than we do in this section of the country. Leigh Watson says as a rule a cancer of the uterus that can be diagnosed by the history of profuse or bloody flow for several weeks, or if a tumor can be felt, has progressed beyond the border line between possibility and impossibility of cure. Cervical cancer soon involves the lymphatics and extends into adjacent tissues. The size of the growth does not always indicate the amount of involvement of the pelvic lymphatics. The growth may appear to be quite recent, and yet metastases may be present.

Lines of Extension.—Continuous extension of cervical cancer along the surface takes place exclusively toward the uterine body, and in superficial carcinoma of the mucus membrane the disease often secondarily involves the entire inner surface of the uterus. The pelvic connective tissue is attacked from the periphery of the cervix, first at the point where the carcinoma has penetrated most deeply; becoming involved latest in superficial mucus membrane carcinoma and earlier in deep infiltration of one wall. The apparent steady increase in the number of cases of cancer, and the increasing death rate, make it unquestionably the most important problem before the medical profession to-day.

Roger Williams, who has made numerous statistical studies, ventures the assertion that cancer is four times as common as it was fifty years ago, and the very exhaustive investigation made by Dr. Wm. B. Coley and published in the January, 1910, number of Journal Surgery, Gynecology and Obstetrics, says that it is a remarkable fact that a disease so widely prevalent as cancer and has from time immemorial held first place in the amount of suffering that it inflicts upon its victims, and is now approaching first rank in the number of those victims, should have received such meager attention from both local and national boards of health.

Anti-Tuberculosis leagues have become universal. Government boards of health and scientific medical bodies all over the world have long since instituted a well organized campaign against the white plague with results that even now justify the hope of speedy control with a possibility of ultimate conquest. While much has been written upon the question of the increase of cancer, most authors are agreed that heredity plays no important part in the occurrence of cancer, and all are agreed that local or long continued irritation of a part is of undoubted importance as a determining factor in the production of cancer wherever located. As may be illustrated in X-Ray irritation of the integument as often observed on hands and arms of X-Ray operators. Warts, scars, moles on the surface of the body, scar tissue in the internal organs, and cancer of the lower lip so often seen in pipe smokers. This fact should be of great importance in connection with the preventative treatment.

Symptoms.—Much has been written upon the subject of early diagnosis of cancer of the cervix, and we all recognize the importance of it, for in all of these cases there is a time when the disease is entirely local, and during which time complete excision would in all probability be followed by complete cure. While the general

practitioner is often blamed for the late diagnosis, yet I am quite certain that in cancer of the cervix, as a rule, up to the time when the disease has reached the border line as to possible cure, there are absolutely no symptoms to attract the attention of the patient or cause her to suspect that she is suffering with any disease of the uterus. Therefore, it would seem to me that if we are ever to attain the early diagnosis so much desired, and of such great importance in this disease, it must be through education of the laity, and impressing upon women who are passing through or have reached the menopause, the necessity for examination at short intervals of the uterus to ascertain the condition of the cervix. The general practitioner can do much along these lines by advising women of the importance of early repair of all cervical lacerations, and of the necessity of frequent examinations between the ages of 35 and 55. The tendency of this would be to encourage women who have reached the menopause to seek medical advice at the first appearance of any abnormality that may have a possible connection or suspicion of carcinoma of the cervix. In Germany and England especially, has work been carried on recently through popular propaganda with results that are very encouraging, in so far as the increase of operable cases are concerned. That the free discussion of so important a subject is desirable none will deny. The fact that 28% of cancers attacking the female sex are uterine in origin, and the fact that one out of nine women who reach the age of 35 will die of cancer is sufficient to show the extent of this disease, and the urgency for means being taken to combat it. It is estimated that there are 80,000 cases of cancer in the United States, and that 40,000 deaths occur annually from this disease. Cancer causes more death in women at the present time than tuberculosis.

The Question of Operability.—This is of great importance, and one that is harder to determine, as that which one operator would consider advanced or inoperable, another would consider operable. As a rule, any case that has reached a stage where either through extension to the parametra or metastases to the lymphatic makes complete removal of all diseased tissue impossible or very doubtful, operation should not be encouraged, as early recurrence is certain and unless all affected tissue can be removed, and with it a liberal margin of healthy tissue.

In this country patients suffering with cancer of the cervix either apply to or are referred to the surgeon late in the disease, and the percentage of operable cases would be scarcely one in six or eight.

Jacobson has found that the percentage of operability is

twice as great abroad as in this country. This undoubtedly being due to the campaign of education regarding cancer which has been waged abroad for some years.

Prognosis.—The mortality in operations varies with different operators, and depends to some extent upon the operation, as in vaginal hysterectomy there is a very low percentage of primary mortality, and a very high percentage of recurrences; while in the radical abdominal operation the primary mortality will be high and the recurrences somewhat lower. The statistics showing permanent cures as reported by Salinger of Chicago in Medical Review of Reviews give Ott's series 36.2 per cent of patients alive and well after five years, and free from any indication of recurrence. Reinecke, 27.5 per cent of cases after five years in cancer of the cervix.

Winter has recorded 148 recurrences which were distributed as follows:

115 in the first year, or 77%; 13 in the second year, or 8.7%; 13 in the third year, or 8.7 %; five the fourth year, or 4.5%; and 2 the fifth year, or 1 1-5% .

From these figures the fact is evident that fewer than half the cases successfully operated upon live beyond one year, and none of the late cases at all. The results are anything but satisfactory, and our only hope for cure in a greater per cent of these cases is yet to be found in some treatment other than hysterectomy. What it may be I do not know, but have hope that some immunizing serum may yet be discovered.

Treatment.—Must be either paliative or radical abdominal operation. If the diagnosis is made early before extension is probable, the radical operation should be advised. Vaginal hysterectomy, as a rule, should have no place in the treatment of cancer of the cervix in the ordinary surgeon's hands, if at all. As the opportunity of complete removal of all infected tissue without serious injury to the ureter or adjacent viscera is not good, owing to the close proximity of these structures to the cervix and the prospect of complete removal with sufficient portion of the vagina is much better if the approach is from above.

End Results.—This is the most interesting and at the same time the most discouraging part of the problem, and the question necessarily arises, are we doing what is best from a surgical standpoint when we operate in advanced cases of cancer of the cervix? Does it not have a tendency to discredit the operation as a whole, and neither prolongs the life of the individual nor lessons the suffering? I am convinced that many of these cases can be treated

best by palliative measures when seen in the advanced stage with undoubted extension around the cervix. The actual cautery or galvano cautery offering the best means of relief.

I myself, and others, whose work I have knowledge of often undertake a radical operation with the hope of at least lessening the suffering of the patient when palliative measures should be advised. The radical operation being reserved for early cases where the prospect for complete removal of all infected tissues is not in serious doubt.

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SOME CONSIDERATIONS IN THE DIAGNOSIS OF OTITIS MEDIA AND ITS COMPLICATIONS IN INFANTS AND CHILDREN.

E. N. ROBERTSON, A. B., M. D., Concordia, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

The writer does not presume to present in this paper anything new and startling. The subject of otitis media is a trite one, yet every one who sees and treats any considerable number of cases, and reads the current literature concerning these conditions, observes many points profitable for discussion. While recently looking over the records of some of my cases of otitis media, treated during the past six years, it seemed to me that there were enough interesting manifestations in those cases occurring in infants and children up to the age of puberty to warrant a discussion of this subject by itself. It is my purpose, however, to largely limit the thought to the diagnosis of these conditions, and in this connection to cite cases and emphasize all such points as have appealed to me as practical. Many of them, no doubt, have been brought to your attention before, both by your experience and reading, but it is my hope that the things herein presented will not prove altogether uninteresting.

Every physician undoubtedly recalls instances when he has been called upon to treat discharging ears in children whose parents had no knowledge of the trouble until the discharge appeared. Frequently by the time he is consulted considerable damage has already been done to the affected ear, perhaps enough for the establishment of a chronic otorrhoea. The child may have been fretful and have had a little fever, but because either of lack of pain or inability on the part of the patient to direct attention to the seat of the lesion, the ear was not suspected as the cause. Pain in a child too young to tell about is easily overlooked, even by the physician himself, It is well known also that acute tuberculosis otitis media practically always comes on with-

out pain. In other instances children are known to work at the affected ear, press it against warm objects and incline the head to the diseased side. In such cases the parent, if observing, will be able to locate the cause of the trouble.

Again, children may be so violently affected by an oncoming otitis as to suggest meningeal or brain complications almost from the start, and it is in these cases that the physician is always called and should be especially alert in establishing the diagnosis, for delays are dangerous.

My attention was first called to the importance of a routine examination of children's ears by an instance which occurred rather early in my professional career. A little girl six years of age living in our neighborhood had been sick for about four days. The family physician, a man of experience, had been in attendance, but was unable to determine the exact cause of the child's illness. There had been fever ranging from 101 to 103, a corresponding pulse, considerable nervous irritability, and occasional vomiting, but no sore throat, bronchitis, or any thing definite in the judgment of the physician to account for the symptoms. One evening the child became delirious, vomited again and began to scream. Since I was living near I was hastily called. The child had quieted down by the time I arrived. After hearing the history of the case, I took the temperature and pulse, and before putting my watch back into my pocket, placed it first to one and then to the other of the little patient's ears. She could not hear it with the left ear. Upon examination with the speculum, I discovered an inflamed and bulging ear drum as well as considerable swelling of the posterior superior wall of the canal near the drum.

Being a personal friend of both the family and their physician, I took the liberty of incising the membrana tympani immediately, and got several drops of blood streaked sero-pus, in which I later found streptococci. All symptoms subsided in a few hours, and after about ten days of local treatment the discharge ceased and the incision of the drum-head healed.

This was undoubtedly a case of primary otitis media. Dr. H. Woods, the aurist, in a paper read before the American Otological Society a couple of years ago, spoke of such a condition as a clinical entity, and described the case of a boy aged 10, with temperature 104 and general symptoms, but no localized pain, where the ear, upon examination, was found to be sole cause of the trouble. Upon incision of the membrana tympani and evacuation of the pus, all symptoms were dispelled.

The manner in which infection reaches the ear in cases of this

kind, while not strictly falling under the head of this paper, is interesting. According to Ballenger the staphylococcus pyogenes albus and aureus and the bacillus pyocyaneus are frequently found in the normal middle ear. It is also well known that infectious micro-organisms, innocent and virulent, stay in the nose and throat for indefinite periods of time without doing any harm. They could easily reach the tympanic cavity. They could also come from the circulation. It is necessary, however, for the condition of the tissues to be favorable for their rapid propagation before they are able to excite an inflammatory process. Why should they not, when the soil is made just right by a state of general lowered resistance, first start up their work of destruction in the middle ear as well as in the throat or other part of the body?

In this connection I wish to speak of a case I saw about two years ago. It was an infant of four months and had been ill about ten days. The physician who was called had treated it for an inflammation of the throat for several days and as its general condition grew gradually worse a diagnosis of meningitis was made. Under treatment for this condition no improvement was apparent and after a day or two the physician said he could not do anything further for the child, and that it would probably die. It was then that counsel was requested and I was called. On inspecting the throat I found the trouble there had subsided, as the mucous membrane was quite normal in appearance. There was, however, a moderate amount of purulent discharge coming from the ears. The babe had been so sick that no particular notice had been taken of the ears. There was no question in my mind at that time either as to the doctor's diagnosis or prognosis. In spite of everything that could be done, the infant died in about forty eight hours. No operation was performed. The question, however, that arises for our consideration here, is what would have been the outcome of the case if the ears had been carefully examined for evidence of middle ear inflammation during the first few days of the infant's sickness?

I recall another case, reported by Woods, which is of special interest here. It was also an infant, five months old, which, three days after the disappearance of an eruption of chicken pox, had a convulsion, with dilated pupils, rigidity and unconsciousness. Rectal temperature was 103, no diagnosis was made at the first visit of the family physician, although the ears were suspected and examined. That night the child improved so much that it took its bottle eagerly and appeared quite recovered. Before morning, however, it had two more convulsions. The physician, being

summoned, brought Dr. Woods with him, who found one of the ear drums and posterior superior walls of the auditory canal swollen and bulging. Without anesthetic this was freely incised, pus was evacuated, and recovery uneventful.

In general it may be said that the large majority of cases of acute otitis media, with spontaneous rupture of the membrana tympani, terminate favorably, and rarely does infection extend to the brain, since, with proper drainage, the suppurative process does not continue long enough to break down mucus membrane, bone and other tissue enveloping it. In the case of infants, however, it is quite different. At birth the different parts of the temporal bone are still ununited by ossification and do not become so until after the first year. "The vascular and cartilaginous lines of union offer less resistance to the transmission of micro-organisms to the cranial cavity". We also know that the tegmen tympani, or roof of the tympanic cavity is, at best, only a thin plate of bone, and when ossification has not taken place nothing but a membranous structure separates the tympanum from the cranial cavity. When, therefore, infectious material is confined in the middle ear before rupture of the membrana tympani, many times the point of least resistance is toward the brain rather than the ear drum. These facts explain not only the meningeal irritation seen in many cases of oncoming otitis, but also the marked cases of meningitis.

The main point, however, which I wish to emphasize, is that in the case of children otitic infection does not always show itself in the regular order described in many text books. As has been shown in the cases cited, there is frequently no pain or other symptoms which might lead one to suspect the ear; and in the cases preceeded by a demonstrable inflammation of the throat, the middle ear may become involved in an insidious manner. Hence, nothing but a routine examination of the ear drums by one able to appreciate the significance of the findings there, can demonstrate the cause of the general illness.

As an aid to the diagnosis of middle ear trouble in children, I wish to speak of a procedure described by S. Blum, in the Medizinische Klinik, Berlin, a few years ago: On placing the finger behind the angle of the jaw in the groove formed by the inferior maxillary bone and the anterior border of the sterno mastoid muscle of the affected side and pressing upward and inward toward the auditory canal, evidence of pain is elicited. In his last report, after having tried this in more than two hundred cases, he claims it to be a constant manifestation in otitis media, and of special diagnostic value in infants. In the cases in which I have thought

to make use of this sign, it has proven to be just what the author claims for it, and it seems to me that it is worth while, particularly for those who may not feel qualified to make an authoritative otoscopic examination.

In children who have passed safely through a few days of middle ear inflammation, with and without a spontaneous rupture of the membrana tympani, there frequently appears not only a reddening of the skin behind the affected ear, but ofttimes swelling and even pus formation, with a varying degree of outward bulging of the auricle. Our first thought has many times been of a possible subperiosteal abscess, but upon noting the rapidity with which cases of this kind clear up after free drainage to the middle ear has been established, we learn that such is not the case. The ring of bone (annulus tympanicus), into which the membrana tympani is attached and which, together with the ear drum, forms the outer wall of the tympanic cavity, is incomplete for about two millimeters in the upper section of its's circumference, forming the so called Rivinian notch. At this point the drum-head is attached to the free tympanic margin of the roof of the osseous meatus. The liability of pent up infected secretions to leave the middle ear cavity at this point seems to be very great in children under five years of age. The pus then burrows along between the bony meatus and skin and cartilage until it forms a swelling behind the ear. In the majority of cases of otitis media in young children, which have come under my observation, varying degrees of this condition have been present. When the condition is very marked, otoscopic examination reveals a very prominent bulging forward of the deepest part of the upper and posterior portion of the wall of the external auditory meatus, so that the background is hidden more or less completely. In cases of this kind it is hardly possible to get to the ear drum and the incision must be made through the most prominent part of the bulging wall. The fact that this condition occurs so constantly in children before the development of the mastoid cells leads one to assume that, in those cases where the infection does not early break down the barriers to the cranial cavity, less resistance is offered to the penetration of pus through the Rivinian notch than through the mastoid cortex.

A. B. Duel, at the Williard Parker Hospital, N. Y., while observing some one hundred cases of otitis media, complicating scarlet fever, measles and diphtheria in children, noted post auricular swelling caused in the manner described above, in the majority of his cases under five years of age. Between the ages of five and

ten the post auricular swelling was of the true subperiosteal variety. In still older children swelling over the mastoid was comparatively rare. Post auricular swelling simulating the above condition, may occur from furunculosis of the cartilaginous portion of the auditory meatus, and thus be independent of middle ear involvement, but this is quite easily differentiated by noting the swelling of the cartilaginous portion of the external auditory meatus.

With the exception of a small percentage of cases where subperiosteal abscess is caused by infection burrowing along the posterior superior wall of the auditory canal and extending by continuity of tissue to the periosteum of the mastoid region, (Mygind of Copenhagan reports 11 out of 100 cases forming in this way), it is now generally conceded by aural surgeons that all cases of this form of abscess are of mastoid origin. Much has been written on the inadequacy of Wild's incision, and it is, of course, because experience has proven that the large majority of subperiosteal abscesses follow upon an involvement of the mastoid with penetration of its cortex, and hence satisfactory results in treatment are rarely obtained unless the underlying infected and necrotic tissue is curetted out. The mastoid cells are not completely developed before the age of puberty, However, the mastoid cortex is at all times less compact than in adults and does not offer so much resistance to the penetration of pus, once it has gotten into the antrum and rudimentary cells with any considerable pressure behind. Hence, subperiosteal abscess is much more common in children than in adults. Mygind reports eighty-five per cent of his cases occurring in children under fourteen years of age.

In these cases the ear is not only bulged outward, but the auricle at its superior portion stands well out, whereas, the swelling behind the ear described above as occurring so constantly in young children, does not extend so high. Macewen says the periosteum over the squamous portion of the temporal bone is more easily separated than that covering the mastoid. Clinically this certainly seems to be true, for in subperiosteal abscess the swelling is as much above as behind the ear in most cases. According to one author (Duploy), it is possible, before the pus forms externally, to feel the elevation and depression under pressure of the external table of the mastoid.

Mygind calls attention to an important point with reference to pain in these cases. He says it is quite common for the patient to suffer severe pain in the mastoid region prior to the formation

of the abscess, which pain disappears as soon as the swelling shows up. One is often deceived in such cases, taking the subsidence of pain as a favorable sign and concluding that a simple incision down through the periosteum will be all that is necessary. In cases thus treated the persistence of a chronic mastoiditis is the price usually paid for our failure to do the right thing at the right time.

The antrum being the only mastoid cell present in infancy and there being such a tendency for infection early to extend from the middle ear to the cranial cavity through the ununited squamo-petrosal suture, or to the exterior through the Rivinian notch, mastoiditis, as such, is less common in infants than is generally supposed, But the disease is none the less to be dreaded; on the contrary, it is much more to be feared, since, when it exists in ever so slight a degree, brain complications are very likely to occur and these many times before the external evidence of mastoiditis has become manifest. When the mastoid cells become sufficiently developed, as occurs from about the third year on, the inflammation practically always extends to them when the drainage is not free; in fact, Ballenger says that all cases of acute suppurative otitis media are complicated by varying degrees of mastoiditis.

Mastoiditis in children presents a few distinguishing features as compared to the same disease in adults. The initial pain is almost always more severe than in adults. Symptoms of meningeal irritation such as headache and delirium are more common and usually earlier present. In infants this is generally manifested by convulsions. All authorities agree that the mastoiditis secondary to the eruptive fevers of childhood is to be greatly feared, since the liability to both brain complications and permanent defects of hearing is much greater than when the disease complicates an ordinary case of otitis media. In addition to these points, mastoiditis in children is most likely to be accompanied by subperiosteal abscess, as has been shown previously, due to the ease with which the external table of the mastoid is penetrated.

The sign now recognized to be pathognomonic in mastoiditis is the sagging of the posterior superior wall of the bony meatus near the drum head. This is called the "dip", and is caused by an infiltration and breaking down of the mastoid cells below and anterior to the antrum, with consequent bulging of the floor of the antrum. Confusion may sometimes arise in the case of young children, since the posterior superior wall of the canal is so frequently made prominent by the burrowing of infected secretions between

the skin and bone. In these cases considerable dependence must be placed on other mastoid manifestations of involvement, and, of course, the case watched very closely after free incision of the bulging wall.

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THE REPORT OF A CASE OF UTERUS SEPTUS WITH SOME UNUSUAL COMPLICATIONS.

W. G. NORMAN, M. D., Cherryvale, Kansas.

Read before the Southeast Kansas Medical Society, September 27, 1910.

The report of this case will exhibit to you one of the frailties of human nature, that of making mistakes. In reporting this case, I do so not because of any skill exhibited in the diagnosis of treatment of the case, but because of the pecularities and abnormalities found. This was the first case of the kind I had seen in 14 years practice, and I thought it might be of interest, at least to those who have never seen similar cases, and might serve as a reminder to all of us that the unsuspected usually happens when we are not looking for it.

The case in hand came to me from Miami, Oklahoma, and was a young married woman, 21 years of age, the mother of 2 children, one 3½ years old, and the other 16 months; a woman of vigorous constitution and had always been of good health until her first baby was born. Her family history was good; mother and and father, brothers and sisters all living, strong and healthy. Her first confinement was extremely tedious ; having an instrumental delivery of a 7 pound girl, after a labor of 72 hours. Following this delivery she had some septic disturbances and 9 days after her delivery she passed what her physician told her was a false conception. She recovered from this confinement slowly and leaving evidently, from her own history, some exudate in her pelvis. There was evidently, judging from what I found when she came to me, a bilateral tear of the uterus, and also a tear of the perineum, at this time. The latter was partially repaired, however.

About 2 years later she had an instrumental delivery of another 7 pound child, after a tedious labor of 48 hours, with only mild septic phenomena following. These deliveries seemed to me, as I got the history, to be rather unusual because the woman is of good size, weighing ordinarily about 140 pounds, and a pelvis a little larger than ordinary. She made a rather tedious recovery after her last confinement, flowing much longer than is usually the case, and being much weaker, but having very little fever.

Following this confinement she flowed at irregular intervals, sometimes only for a day or two, and sometimes scantily for a week or two, until the baby was about 8 months old, at this time she noticed at intervals that she was somewhat nauseated but did not think of pregnancy since she was flowing every few days, but for the next two months she noticed the flow bothered her less often and was less profuse when it came, but at this time when the baby was about 10 months old, she had a fright and a heavy fall, being partially thrown out of a buggy, and following this, she had a terrific hemorrhage, but since she had been flowing so irregularly and so freely, she did not consult a physician, thinking perhaps that it was just the re-establishment of the regular monthly periods. Following the flooding, she began to lose weight gradually, her complexion was sallow, and she began at that time to have flooding spells of pure, bright red blood at intervals of from 2 to 6 days; between these spells the flow was of a serosaneous nature with some disagreeable odor. After this had gone on 4 months, and she had lost some 20 or 26 pounds, she consulted a physician who told her that she had a fibroid tumor, and advised her to have an operation. About 1 month later she came to me and repeated the foregoing history, saying that up to the present time she had lost 35 pounds, and was having more or less pain through the abdomen, and especially in the right side, apparently in the uterus, and the tenderness I found over the abdomen was also on the right side of the uterus. On examination early in the morning, I found her temperature a little below normal, abdomen a little distended, and tender especially just to the right of the medial line, a sallow complexion, some enlargement of the lymphatic glands in the groin, and over the body generally. The urine was loaded with urates and some phosphates. Vaginal examination revealed a uterus 7 inches deep, soft, spongy, apparently empty, covered with villous growths, almost polypoid in their nature with a bilateral laceration of the cervix, and a tumor on the right side of the uterus, which seemed to me to be a subserous fibroid. Dr. Norman concurred in my diagnosis, and a doctor in her home town had also told her that she had a fibroid tumor, as also had Dr. Baird of Coffeyville, so I advised her to have the cervix repaired and undergo currettage, hoping this would cause the supposed fibroid to disappear.

Accordingly on the 19th day of August, I operated, assisted by Drs. Norman and Seacat, dilated the os, making a gentle currettage and repairing the lacerated os. Patient stood the operation and anesthetic well, came out and got along splendidly for

about 36 hours, when we removed a small uterine pack. About 30 minutes after removing the uterine packing, she was seized with terrific cutting pains in the right side. This pain lasted her for 45 minutes, coming at intervals of from 5 to 10 minutes; was of a sharp lacerating character. We expected a tubal infection. The pain was relieved by morphine but she showed symptoms of severe shock, pulse running very high with little or no temperature. The usual treatment of symptoms of this kind was administered, and gradually she came back to a somewhat normal condition, but complained of more or less pain in the region of the right tube. On examination of the abdomen, we could feel a tumor the size of a hen's egg or larger, on the right side of the womb, which did not seem to be in the tube, and thought the curettage might have caused some hemorrhage in the region of the fibroid, but decided to await developments since the patient was improving all the time. During this time there was quite a free flow of pure blood and we felt encouraged and thought this would relieve the unusual symptoms soon. But a few days afterwards she began to have a discharge with some odor and gradually the pinkish color of the discharge changed to that of sero-pus. We again explored the uterus, but with negative results, finding it perfectly clean, but it had not contracted any since the curretting. She begun to show a little bit of fever, especially in the evening, and was somewhat nervous, complaining of more or less pain in her back and in the right side, the region of the tube. We still thought we had a tubal infection, but decided to wait for a while before doing anything.

Some 3 weeks after the operation, this discharge of pus and mucous having kept up for the last 2 weeks, she passed a portion of a foetus. This was something unexpected by us, and we again explored the uterus but found it absolutely empty. However, in 2 or 3 more days she passed other small portions of bones, and we realized absolutely, that there was a foetus some place in that abdomen. We thought perhaps this might be the in opening of the tube in the womb, intramural pregnancy, similar to a case described in Edgars Obstetrics, on page 408. So I took a curved sound and thought I would try to find and sound the tube. In doing this I aimed to follow the right side of the uterus around from the os up to the tubal opening, but on entering the os the sound following around the right edge of the inner os, passed directly into a pocket, and the thing dawned upon me immediately that we had a uterus septus. I tried to explore this new found cavity, but was unsuccessful since the opening was so very small

and the pain so great that patient would not stand it. Dr. Norman on examination was satisfied of the same condition, and so under anesthetic we proceeded to dilate the mouth of this cavity and removed therefrom some of the cranial and pelvic bones of about a 3 months foetus. When we had this apartment of the uterus cleaned out, we found that it was in somewhat of a crescent shape and that there was a thick sero-fibrous wall intervening between that and the larger cavity of the uterus, and what we had supposed was a fibroid, was this partially decomposed foetus lying in this crescent shaped or smaller compartment of the uterus. The patient from this time on made an uneventful recovery and now seems to be enjoying fairly good health.

This case has been an unusual one in many respects. First, the congenital formation of the uterus is somewhat unusual. Only one case in about every 100,000 women is noted. Second, the difference in the development of the two sides of the uterus. This I ascribe partly to the growth and extra thickening of the walls of the side of the uterus which had developed the two former pregancies. Together with the fact, as Edgar mentions, of some absorption, thinning or dimunition of the walls of the unimpregnated side because of the pressure and because the increased blood supply in the one side would somewhat impoverish the other side of the double uterus. This weakened, and undeveloped condition of the one side of the uterus evidently was the cause of the tedious labors and occasional the use of the forceps in the first two confinements. Third, it is somewhat unusual after two successive pregnancies in one side of a divided uterus, and that side had practically taken on all the functions of the whole organ, that pregnancy should take place in the undeveloped side. It is expected that some trouble would be experienced from this pregnancy, and the death of the foetus at 3 months from pressure or lack of blood supply would not be unexpected, but that the foetus should remain in utero 6 months after death, causing so few symptoms leading one to think of such a condition is again unusual. And a profuse hemorrhage from a uterus gradually absorbing poison from a decaying foetus contained in one compartment of itself without any effort to throw out the offending material by contraction or otherwise, is as misleading as we usually find in clinical symptoms. Fourth, it is unusual for six physicians to make a more or less complete examination—less perhaps you will say—of a case and all come to the same conclusions, and all fail to find a condition so obvious as a divided uterus. But I contribute this failure to the fact that no one examined her before her first pregnancy,

and I think during that time the septum was partially absorbed below and so pushed to one side that it was hard to detect unless you were looking specifically for the condition. Then too, perhaps, the lacerations of the os being deepest on the right side, causing more or less inflamatory action in the surrounding tissues had caused some adhesions of the septum to the wall of the undeveloped side, and in that way the opening into the right or undeveloped side of the uterus was made very small and was so far to one side of the uterus that the ring or internal os almost completely obscured it.

So gentlemen, if I have failed to arouse any interest in this somewhat unusual subject, I hope I have paved the way for some sympathy for a fellow practitioner who may happen onto such an unusual condition and who, may unless very fortunate like myself, in having a very patient and long suffering family, happen onto a great amount of trouble and embarassment in explaining this unusual phenomenon. However, little as you may have gotten from this article, I have had the lesson impressed on me during this case that one should never fail to exclude every possible condition, however remote, in making his diagnosis, and then he may need, as old Dr. King told us in our student days, to always leave a gap down so as to have a ready means of escape.

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Pain in the Back.—If one goes over the history of patients suffering from Bright's disease, from stone in the kidney, or from septic infection of the kidney, it is surprising to note how few cases, if any, have pain in the back; that is to say, pain referred to the vertebral column. In most of these cases the pain is a dull ache or soreness referred to the lumbar region, and in the case of colic it is usually referred along a definite path. So, also, the number of cases of pain in the back, popularly referred to some displacement of the pelvic viscera, is far too great to have any definite scientific reason for localizing the cause in that region, and the proof of this lies in the fact that so many of the leading gynecologists of the day are very conservative in their operating on this class of cases.—Turner, in the Montreal Medical Journal.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, J. E. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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EDITORIAL

The annual meeting of the American Medical Association held at Atlantic City last month, was a successful one in every particular. The attendance was 3,600, which is slightly less than at the meeting held there in 1907. The scientific sections were replete with brilliant papers and the work all through was above the average. The social functions were all that could be desired.

The society will meet next year at Minneapolis, which will probably bring out a larger gathering from the middle west.

The officers elected for the ensuing year are as follows:

President-elect, Dr. John A. Witherspoon, Nashville, Tenn. First vice-president, Dr. Philander A. Harris, Paterson, N. J. Second vice-president, Dr. John L. Heffron, Syracuse, N. Y. Third vice-president, Dr. H. H. McClanahan, Omaha. Fourth vice-president, Dr. Henry D. Fry, Washington, D. C. Secretary, Dr. Alexander R. Craig, Chicago. Treasurer, Dr. William Allen Pusey, Chicago. Trustees: Dr. M. L. Harris, Chicago; Dr. C. A. Daugherty, South Bend, Ind; Dr. W. T. Councilman, Boston.

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There seems to be considerable misunderstanding of the working of the Medical Defense feature of the society. A good many members seem to be under the impression that it is an adjunct of the society and requires some special action on the part of the members to participate in its benefit. Soon after the adoption of this feature, circular letters accompanied by copies of the amendments to the constitution and by-laws were mailed to every member of the society. It may be well to again explain that every member of the society who is in good standing is entitled to participate in the benefits of the defense fund under the provisions of the amendment.

The Defense Board is now in charge of the defense of four suits for mal-practice. One case was dismissed a few days ago. Of the four now on hand, one case will come up for trial or be dismissed within a few days. Another case, in which there was a hung-jury at the last trial, will come on for re-trial shortly, and the other two cases will come up in the fall.

Three of the cases which the Defense Board has been called upon to defend have been investigated by attorneys, who have thought there was an opportunity to make something for themselves in a contingent fee. In none of these was there any meritorious ground for a suit or the slightest doubt as to the proper attention having been given by the physician and in each case the services were unrewarded and at least in two of the cases mere gratuitous.—W. E. M.

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It is too frequently the case that the first thought of a damage suit is brought to the mind of some physician's patient by the careless remark of another physician. We are entirely too ready to express our judgment upon the work of another man without first getting a full knowledge of the case. A thorough investigation will in most cases show that the physician or surgeon has been fully justified in the course he has pursued but we are all likely to make mistakes in judgment, and it is no part of our duty as medical men to criticise another for what we may consider an error of judgment. We have found that most medical men who have been involved in a damage suit, are mighty careful to keep their opinions of another man's work entirely to themselves. It is a good system.

We further believe that no physician or surgeon should engage to testify as an expert in any case until he has had an opportunity to carefully investigate both sides of the case. Considerable humiliation to the witness and great disappointment to the side engaging him, have sometimes occurred when evidence, of

which the witness was uninformed, was brought out at the trial in regard to the nature of the case.

If medical men had more confidence in each other, at least more confidence in each other's fairness, many damage suits could be avoided. Some years ago a physician in a small country town had for a patient a man who had, in a collision, gotten a badly shattered leg. He thought there was a chance to save it and did so. The leg had lost some of its beautiful contours and was somewhat shortened but it was serviceable and could be used without a crutch or cane. The patient thought it should have been better and threatened suit for damages. The physician suggested to the man that he show his leg to an eminent surgeon in a neighboring city and wrote out a description of the injury which was approved by the man. When the surgeon had read the description of the injury and examined the leg he told the man to go back to his physician, pay him his fee and thank him for saving his leg. "For," said he, "if you had brought your leg to me I would certainly have taken it off." The man was satisfied, the damage suit was never brought, and he paid the physician for his services.—W. E. M.

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THE FEATURE OF FEES.

A great deal is being written of late, for the magazines and newspapers, about the doctors. Never before have doctors as a class appeared to be of so much public interest. Among other criticisms of the profession that have been offered we find the custom of splitting fees with the surgeon or consultant has been a most attractive subject for popular magazine writers and some reputed eminent physicians. We will not go into the justice or merits of the charges that have been made but simply attempt to point out some of the things these criticisms ought to suggest.

The profession has spent a great deal of energy for the public weal, with very far reaching beneficial results, but it has failed to re-adjust its relations to the people in harmony with the economic principles which now govern the world. It has accomplished a wonderful work in advancing the science of medicine and in improving the standard of qualifications for the practice of medicine, but it has left to chance the solution of a problem in which every physician is most vitally concerned—an equitable system of remuneration.

The fees of the general practitioner are regulated upon the same basis that governed his charges a century ago. He is permitted to charge so much for a visit and so much for a prescription, according to the customary charges of the physicians in his

locality, without regard to the nature of the case or the skill required in its successful management. With the great increase in the standard of qualifications for a practitioner of medicine, the many instruments of precision he is required to use, and the various laboratory procedures he is compelled to carry out in the diagnosis and successful treatment of his cases, such a system of charging is entirely inadequate.

While the surgeon is not handicapped in the same way there is such an evident lack of system in his charging that against him the severest criticism is directed. That the fees among different surgeons will vary from $25 to $300 for the same operation is due simply to the various estimates which they themselves and the people put upon their individual skill, but when the fees of a single surgeon vary from $25 to $300 for the same operation the people are likely to conclude that his charges are based upon the financial standing of the patient or his friends. There are perhaps surgeons and eminent consultants with whom the patients pocket alone determines the size of the fee, but we are not personally acquainted with any such. Certain surgeons with a national reputation, operating a large hospital and drawing their patients from all parts of the United States, are said to depend entirely upon the financial condition of the patient in fixing their fees. We recently heard a banker, who had paid a very large fee for a very small and simple operation, lauding their generosity in refunding the fees of some patients who were less able to pay than himself. As a general rule, however, surgeons, though they may appear to the people to follow this rule, do not over-estimate their services in fixing a fee for their wealthy clients.

The trouble is that people have become so accustomed to the charitable freedom with which the physician or surgeon reduces his fee or surrenders it altogether, according to the degree of poverty of his patient, that they no longer appreciate the real value of the services rendered. Our City, County and State Governments, and the people as a whole have too long regarded the medical profession as a charitable institution. At least one-third of the practice of any well established physician is done absolutely for nothing. This is so fully recognized that the cities and counties make no adequate provision for the medical care of the indigent sick. It is no more just that the physician should render free service to the poor than that the grocer should furnish him free food or the clothier should furnish him free clothing. The burden of caring for the poor should not be borne by one man or one class of men, but by the State.

It is out of the failure to reconstruct the financial end of the practice of medicine in harmony with the conditions created by modern methods of finance, that there has developed the objectionable features most frequently discussed. Fee splitting which is apparently more objectionable to the metropolitan surgeon than to the people, would be eliminated if a fair system of fixing fees for both surgeon and physician could be determined. Contract practice is simply a result of the effort of the people to equalize the cost of sickness and accident and from their point of view it is more equitable than the system they accuse the doctor of following. They believe it is more just for the well people to help bear the burden of the sick than for it to be borne by the well-to-do sick and injured only. If the physician is made the goat it is simply because we have neglected one of the most important features of our business.

It will be much better for the profession to settle this problem than to have it settled by legislation, as is likely to be the case if these subjects continue to be discussed in the public prints. —W. E. M.

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This years casualties from 4th of July celebrations fell far short of the number of previous years. The number of deaths has been reported as 20, and injuries 648. In 1911 there were 59 deaths and 1910, 131 from 4th of July accidents. This is a remarkable decrease and due in a large measure to the enactment of suitable laws and their rigid enforcement. It is to be hoped that there will be a nation-wide movement started to do away entirely with this needless sacrifice of life.

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Dr. C. H. Carson of the "Temple of Health" of Kansas City, Mo., who has been "healing" the sick for many years with slips of tissue paper applied to the underclothing of the patients, died recently from uremia. Various attempts had been made to compel him to quit practice, but his large bank account together with a corps of lawyers, always defeated the purpose. It is understood that his "Temple" is still to be conducted by his assistant.

PROCEEDINGS OF THE FORTY-SIXTH ANNUAL MEETING OF THE KANSAS MEDICAL SOCIETY.

MEETING OF THE COUNCIL.

Hutchinson, Kansas, April 30, 1912.

Meeting called to order by President J. T. Axtell, of Newton. Roll Call and Reading of minutes postponed, Secretary C. S. Huffman, not being present.

Reports of the members of the Council called for.

Following councillors present: Dr. Preston Sterrett, Kansas City; Dr. H. B. Caffey, Pittsburg; Dr. W. E. Currie, Sterling; Dr. A. D. Jones, Wichita; Dr. C. S. Kenney, Norton and Dr. W. F. Fee, Meade.

The following members read their reports, and handed them to the Secretary: Dr. A. D. Jones, Dr. C. S. Kenney and Dr. H. B. Caffey.

The following members did not hand in reports, but their remarks follow here below: Dr. W. F. Fee, Dr. Preston Sterrett and Dr. W. E. Currie.

DR. W. F. FEE. Mr. President and Gentlemen—I am glad to report that we have every man in our District in our Medical Societies with the exception of three who live in Counties in adjacent territories with no railroads. A few years ago we organized the first Society in my District, by putting three Counties together, Meade, Seward and Stevens Counties. Last year I organized Commanche county, taking in the towns of Ashland, Coldwater and Englewood. All the physicians in that county belong to that society. This year I organized the Kiowa county medical society. Every physician in Kiowa county belongs, so that while we live in the most sparsely settled part of the state, yet we can say we have practically all the physicians in our society. I have talked with members of the different societies relative to going over into some of the counties with but one physician, and having them come into the society of another county, but most of them thought it was not advisable, and that the expense was too much. However, there is a new railroad going in west of Dodge City, and I presume another society will be organized in that district. Outside of this, we are all organized and pulling together.

The last society which I organized, was with the help of Dr. Willey, that very modest gentleman sitting there in the corner. We got all the physicians in Kiowa county together. One old man, practicing all his life in Greensburg, when I first talked to him a year ago, thought it was all foolishness and did not want any-

thing to do with it. The facts were, he never did belong to a medical society, but now he is very enthusiastic. He is now president, and very much pleased with the work of the society. A short time ago, the society met at his home, and I was invited to be up there with the society. We had a splendid banquet and a very pleasant evening.

I am glad to say, that as far as the Southwest is concerned, we are working in harmony with the State Society.

DR. PRESTON STERRETT.—Mr. President and Members of the State Society.—I have nothing particularly to report from our society. Our members are not scattered, as in the western part of the state; we are located in the eastern part, and also well organized. Everything is going nicely. We thought we might have some trouble to bring to this society, but we have not. We now have ninety members in our society, and the membership has just doubled in the last year.

DR. W. E. CURRIE.—I cannot tell much about this district. We have done a great deal since our last meeting. At Topeka, a year ago, I reported what we had done at that time.

During the first part of the year, I visited a number of county societies. Barton county was re-organized at the first of the year and had not been together for several years before. This society is getting along fine now.

There is nothing new in the other counties. Harvey and Peabody societies are joined together in one society.

We have something that might interest you, and that is a chiropractic. We fined him $50.00 last week. However, he has appealed the case to the District Court, and given bond for appearance. I wrote the County Attorney a few days ago that he was still practicing. He said as soon as he had eight complaints he would start with eight counts against him. This is what we are now working on, and in a few days we expect to have eight or ten counts against him, and hope to fine him on each count. There will be no trouble in convicting, I think, but he told one of our Doctors that there had been eight such cases tried in the state, and that they had been successful in four of them, and he thought he would be successful in his case. However, I think he is mistaken.

DR. H. B. CAFFEY.—Mr. President and Members of the Council.—The counties of the Third District; Cherokee, Crawford, Bourbon, Allen, Neosho, Labette, Montgomery, Wilson and Woodson have not required the services of a Councillor during the past year and I am pleased to be able to say that all is peace and harmony with us.

The District Society meets twice annually, bringing together more than fifty of the wide-awake doctors representing every county in the district. This gives us an exceptionally good opportunity to get together and discuss things of mutual concern, as well as matters of scientific value to us all.

On account of the meetings twice during the year it makes the work of the Councillor quite easy and brings about better results than would be done by visiting the counties individually.

I think every Councillor district in the state should be organized as a whole, with at least two meetings during the year.

DR. C. S. KENNEY.—Mr. President and Members of the Council.—I beg to report that the Ninth District, comprising the counties of Cheyenne-Rawlins, Norton-Decatur, Phillips and Smith, has four societies organized. The same policy followed by other thinly populated districts in Kansas, has been followed; and Cheyenne-Rawlins, and Norton-Decatur are joint societies, Phillips and Smith have separate organizations. The Norton-Decatur society is the oldest in Northwest Kansas, having been organized in 1890. Cheyenne-Rawlins society was chartered in 1911. Owing to so few members, the Norton-Decatur and Cheyenne-Rawlins of the Ninth District, and the Tri-County and Western Kansas, of the Tenth District meet jointly every sixty days, at some central point. In this manner the interest is kept up.

Phillips county has not been visited by the councillors on account of the society not meeting. There does not seem to be much interest in the county. The Smith county society took on new life and had a rousing April meeting and the future looks bright, for the society.

The first district meeting was held in Norton, February 20. The tenth district joining. This was a great success and will now be an annual event and in all probability a society will be organized in December, as the Ninth District Medical Society.

One of the plans in this district is to have the scientific program in the afternoon, and to have a popular lecture in the evening, to which the public is invited. This has been done a number of times and is meeting with popular approval. It has not been difficult to obtain some man of reputation to speak on sanitary or health matters to the public, and it will not be long until it will be possible to have a popular lecture at the close of each session in this District.

Dr. Axtell called on Dr. A. D. Jones, to say something of the prosecution of Professor Samuels, of Wichita.

DR. A. D. JONES.—The prosecution was started against Dr. Samuelson by the State Board of Health, for not labeling his product. Professor Samuels has since left Wichita, and has gone to Detroit, Michigan. The local people, he said, did not appreciate his ability and good work, so his reason for going. This man's eye-water was examined and found to be a little salt water and sugar.

President called for the report of the editor of the Journal for the State Medical Society, which was read at this time.

GENTLEMEN.—Your editor begs leave to submit the following report, first as to the financial condition:

Amount received from advertising and subscriptions	$1490.53
Amount received from State Society	1000.00
Total	$2490.53

Amount paid out as follows:

Twelve Issues of Journal at $105.00	$1260.00	
Postage	63.21	
Envelope Wrappers	45.00	
Cuts and extra insert	10.40	
Commission for advertising	8.25	
Editor's salary	1000.00	
Total		$2386.86
Substracting expenses		2386.86
from the receipts		2490.53
leaves a balance to be returned to the state society of		103.67
There is now on the books for the past year to be collected		161.67
By this report you will see that when the accounts are collected, the Journal will cost the society for the past year		734.66

At the last meeting of the Council, I was instructed to attend a meeting of the Editors of the State Medical Journals, held in Chicago, February 26th. The meeting was for the purpose of arriving at a plan suitable for increasing the amount of advertising carried by the State Journals. The meeting was held at the American Medical Association, and was attended by the editors of nine of the State Journals, together with W. C. Braun, advertising manager of the A. M. A. Journal. Various plans were discussed for pooling the advertising interests of all the State Journals, who cared to enter the combination, and the following agreement was reached:

First.—That the committee composed of Drs. A. E. Bulson, Wilfred Haughey and George Edwin Baxter, representing the editors of the Illinois Medical Journal, Michigan Medical Journal, Ohio Medical Journal, Missouri Medical Journal, Kansas Medical Journal and the Journal of the Wisconsin Medical Society enter into contract for twelve months with Mr. John W. Judson to act as their advertising representative with headquarters in Chicago, upon the following terms:

First.—That the above named journals pay the said Judson a commission of 33⅝ % for all new business obtained by him. The Journals shall not be responsible to any agencies for any commissions whatever; any such commission shall be paid by Mr. Judson. Commissions shall be paid quarterly upon presentation of bill from Mr. Judson to the Editor.

Second.—It is agreed that a commission be paid for all new business obtained through the efforts of the representative, but that any business which comes direct to the office of the Editor without any soliciting on the part of Mr. Judson, no commission shall be allowed said Judson. If, however, the representative should visit the local community of any Journal and secure new business he is to be allowed a commission therefor.

Third.—It is agreed by the Editors and John W. Judson, that commissions shall be paid the said Judson on all new business and all renewals obtained by him during the life of this contract.

Fourth.—It is agreed by the Editors and Mr. Judson that no contract shall be made with any firm by either Mr. Judson or any of the Editors at any figure less than the regular published advertising rates of the several Journals.

Fifth.—The editors agree to pay the said Judson $50.00 per month to be used by him for expense money. This amount to be paid share and share alike by the Journals upon demand of the Treasurer of said committee.

Sixth.—Each editor agrees to furnish said Judson with stationery, contract blanks, rate cards and a statement each month of any new preferred space which is for sale and any information that they may have which will be of service to him in soliciting advertising, such as correspondence relative to advertising.

Your committee representing the Editors of the above mentioned Journals recommend that no new advertising be received that has not been approved by the Council of Pharmacy and Chemistry of the American Medical Association and that any Journal which contains advertisements not approved by the Council, shall eliminate these advertisements from their pages, and the committee

further recommends that no Editor shall become a party to this advertising campaign who does not adopt this policy of clean advertising. We feel that the opportunity is at hand for all the state Journals to take a decided stand. The Journals of the Mississippi Valley can set the pace and all the other State Journals will soon see that clean advertising can be made a paying business.

Your committee recommends that a fund be established to be known as a drawing account for the said Judson which in reality shall be an advancement of commissions for new business, and that each Journal shall send to this fund 33⅝% of its flat rate for one and one-half pages. This is to be charged on your books to John W. Judson, and credits be made him as soon as he sends contracts for new business.

The committee recommends further that each Journal charge not less than $50.00 per page per 1000 circulation per year. It is understood of course that this rate does not prohibit any Journal from establishing a higher rate.

Your committee after much discussion reached these conclusions and made the proposition to Mr. Judson and the above terms are the result of this conference. We believe this offers the State Journals a splendid opportunity to secure a considerable amount of new business in the course of twelve months. It will take the representative some little time to work up new business, but we firmly believe it can be done.

Mr. Judson comes to us very highly recommenedd by Mr. Braun, of the American Medical Association, he left a position paying $3,000.00 per year expecting to take an $8,000.00 per year position with Harper & Co., but lost the position through some business chicanery. Mr. Braun states that Mr. Judson can get a $3,000.00 a year position any day, and the reason he is taking up our proposition is because he thinks it is one that can be developed into a greater proposition. On account of his experience in the advertising business your committee felt it would be well to offer a larger commission for the first twelve months and the expense money in order to get this business properly started. It is understood between the committee and Mr. Judson that the commission be 25% the second year if the contract is renewed.

After returning from Chicago, I received notification that through a misunderstanding, the advertising representative engaged by the committee refused the position which of course for the time being, holds up the proposition. However, the committee are now negotiating with another advertising solicitor, and in all probability, the plan will finally be carried out. It will mean

to our Journal the giving up annually of $264.00 worth of advertising not approved by the Council of Pharmacy of the A. M. A. This space would probably be taken by new advertising approved by the Council of Chemistry of the A. M. A.

All other State Journals, with but three or four exceptions, have already removed all advertising not approved by the Council of Pharmacy of the A. M. A., and I would request permission to do the same.

Respectfully submitted,
JAMES W. MAY, Editor.

DR. MAY.—"In connection with this report, there are two recommendations I wish to make. First, we are carrying $250.00 worth or thereabouts, of advertising, not sanctioned by Council of Pharmacy of the American Medical Association, and I think we should stop that advertising. Second, that some sort of contract relative to advertising, referred to in my report, should be made."

Moved and seconded we exclude from our Journal such advertising as is excluded by the Council of Pharmacy of the American Medical Association.

DR. PRESTON STERRETT.—"It seems to me that Dr.May has sifted this thing down thoroughly, and it seems to me he is the best fitted to judge, and it occurs to me that he would be the best judge relative to this advertising, and I urge that it be put to him as before, and that he throw out what is objectionable.

DR. J. W. MAY.—"I would rather that the Council would speak. I was instructed last year in some way like this, but I did not act. I would rather have the Council come out flatly and say just what is what. For instance, take a preparation of antiphlogistine. Many doctors use this. It is thrown out by the Council on Pharmacy of the American Medical Association, because of the claims made relative to what it will do. There is no objection to this glycerin plaster, it is for its claims. So, it might be with other things, and I would rather have the Council say what we shall do. I think we should do as the American Medical Journal, and many other journals. I would say, take nothing that is not approved by the Council on Pharmacy of the American Medical Association."

DR. H. WILKINSON.—"As I see it, it is the only way. The American Medical Association has attempted a good work, and while they may be radical at times, that is no excuse for Dr. May, or any other editor to work in opposition. There should not be any hard feeling on the part of advertisers as you can charge it up to the American Medical Association."

DR. A. D. JONES.—"There is no better way of improving the Journal than to remove these things. The first thing you see on opening your Journal is these advertisements, and this gives one a first (bad) impression."

DR. W. F. SAWHILL.—"I do not think we can afford this advertising. This advertising is what sells their medicine."

DR. W. E. CURRIE.—"It gives Dr. May a background, and I think this motion should pass."

DR. N. J. WILLEY.—"I think we owe it to the Council on Pharmacy of the American Medical Association. The physician reading those things has no time to look into their claims, and he must as a matter of fact accept some things told by the advertisers. The ideal way is to have advertising you can accept everything said."

Motion voted on and passed.

DR. J. T. AXTELL.—"The question if Dr. May can make a contract as suggested in his report, is before you."

Moved that Dr. May be made a committee of one, with power to act in regard to the acceptance or rejection of this plan. Seconded and passed.

DR. J. W. MAY.—"Another matter that we should discuss here. I have not said all I want to in connection with the report I just gave you. There is no doubt but what the Journal can be much improved. This proposition of having a Medical News column, came up a year ago, but no action was taken. It was suggested once we have a round table discussion and that we have a department editor for it, but no definite action was taken. It would not be a bad plan, I think, if we could have it. Here is the proposition: We have three associate editors, Dr. Sawtell, Dr. O. P. Davis and Dr. C. S. Huffman. I have called on these three men for editorials on questions that confront the Society. I have only gotten one response, and that was from Dr. Sawtell. It is hard to get these men to write. If they would do it, it would mean a great deal to the Journal; it would lend personal interest to the Journal; it would take away the responsibility of the Editor, and would prevent his personal opinions creeping into the columns, as is sure to happen no matter who your editor is. The Editor's personal opinions make up most of the editorials time after time, and if you could have several editors then you could get ideas in concrete form of the men of the State. If I write an editorial on a public question, it may agree with the President but might disagree with the Secretary.

If we had the opinion of someone else on the question, that would effect the interest of the profession of the State, it would lend more readable charm to the Journal. In the state of Kentucky they have a plan that works fine. They have a dozen editors. If they call for an editorial they pick out a subject familiar to the man. Eye subjects for eye men, surgery subjects for surgeons, etc. This man not responding is removed from the staff. This also relieves the responsibility of the editor, and that is no small item, to the editor. The American Medical Journal covers a large field, but there are many things in our State that the Journal of the American Medical Association does not cover. A good plan, I am sure, would be to have about twelve editors scattered over the State and appoint them for one year. When we call upon them for an editorial they should respond. And if they do not respond they should be dropped.

I would like to hear from the Council. I am interested in the Journal, but I know some men never open their Journal. The interest of the state will make the Journal. I cannot do this alone, no one could, and I must have co-operation.

The objection has been made that the Journal does not interest the members of the profession of Kansas. I should like to ask in what way it does not interest them, and want some suggestions as to what will help to make it of scientific interest. I do not believe the members of the Council are here who made these statements. The Journal is not going to reside in Kansas City long, and I should like to see it improve before it leaves. The suggestees make these remarks, but do not make a way or produce a method of treatment. It is easy to sit down and say that the Journal does not meet the requirements of the State in its editorials, and if you could read the minds of the readers, it would be a fine proposition indeed.

DR. J. T. AXTELL.—"I have not given this a great deal of thought. It is true there was some criticsms at the last meeting, but I do not think it was just. I do not think there are many doctors in the State who do not open, read and enjoy their Journal. Where I have been over the State visiting societies, I find the doctors do know what is in the Journal.

"If the State Board of Agriculture wants a report on crops, cattle, etc., in the State, they send out a blank to one man in each county and that has on it, suggestions of information wanted. They compile these reports and learn something worth while. Why could we not send out a sheet of questions to get some news items? This could include marriages, births, deaths and general

news, and be suggestive of what the editor wants, and also in turn helps the editor to know what the readers are interested in. This plan works in other lines, why should it not work here?"

DR. C. S. KENNEY.—"I have nothing much to say, but will mention one matter. I have "chewed the rag" about this thing over and over. I have sent in notes several times, and have had repeated trouble in not hearing from them at all, or having them written up incorrectly, with parts omitted, etc. One typewritten copy never appeared. These are little criticisms that were brought up at our Society at its last meeting. One of these meetings "Balled Up" was that of the district, and the reference to Dr. Crumbine and Dr. Huffman being present, was cut out. I do not know who is to blame, but several of my items have not gone in. I have on account of these things, stopped sending in notes. I would suggest that the Secretaries of the county organizations be appointed as note editors."

DR. J. W. MAY.—"I have felt that to make the twelve councillors as editors would be a good plan."

DR. W. E. CURRIE.—"Inasmuch as council members are around over the territory, I would suggest the plan whereby they would be considered associate editors. The plan of the secretaries of the county organizations is not as good, I think, because they do not go over the territory, and probably know little of it except through their Journal, and their interest in their local society. So far the election of associate editors has resulted in nothing, but it seems to me we would get more out of the associate editors to make the various councilmen editors.

DR. W. F. SAWHILL.—"Perhaps we expect our Journal to be of too high grade, scientifically. Good papers should be published of course, but the plan for each councillor acting as editor, I do not feel can be depended on either. I think the local secretaries should be made editors. There is much interest in local notes, and with this addition this is as good a Journal as we could expect or need."

DR. W. F. FEE.—"If council members are made editors there will have to be some system. News notes are not all the Journal editor wants. News items in the Journal will lend to the reading interests, but editorials are of great interest, and men who can write editorials will be writing something that will be read and appreciated, indeed. But, there will have to be system. Otherwise, they will bunch editorials some months, other months no editorials. I should like to ask Dr. May what his idea is in this matter."

DR. C. S. KENNEY.—"To make such a change, that is to make our council members editors, some action will have to be taken relative to our present by-laws, I believe."

DR. AXTELL.—"I do not think we are just ready now, but should take this up at a future meeting."

DR. J. W. MAY.—"My idea is, each council member be an associate editor. Any editorials may come from the associate editors. All news notes can come through the associate editor. He is reporter for his district. There should be twelve associate editors. Each editor does not have to send in an editorial each month. They know what is of interest, they know what should be said in their particular districts, and if they want to write on something national, that is all right. The proposition we now have is a failure. It has been a failure ever since we started. It has been an honorary position with no work so far. If this new plan does not work out, it would be as easy to rescind as the present one. We can make no mistake to try it. The responsibility would be on the shoulders of these associate editors for anything that was printed, and this would be published over the name, or the initials of the man at least."

DR. J. T. AXTELL.—"I am not sure we will be in order to make a motion to cover this now. I think we will have to make some change in our by-laws."

Moved and seconded this matter be deferred until the meeting of the council, May 2nd, at 8 a. m. Motion carried.

Meeting adjourned.

MEETING OF THE HOUSE OF DELEGATES.

Meeting called to order by President, Dr. J. T. Axtell, Newton. Roll Call.

DR. C. S. HUFFMAN.—"In calling this meeting tonight, I hardly adhered to the by-laws, but having only two days, I thought it better to do this work to-night. I am very sorry I was detained on the way, and that I was late in getting to this meeting.

Report of the Secretary was called for and read:

To The House of Delegates.—The Secretary wishes to submit the following report for the year ending May 1, 1912.

The paid up membership of the Kansas Medical Society is larger than ever before. While some county societies have been delinquent and allowed the interest to lag, the physicians in the whole state are more awake to the needs of the profession, and the benefits to be derived by active participation in society work, than

ever before. I believe the interest and work done by our component societies, will compare favorably with that done in any other state. The amendment to the Constitution and By-laws, providing for Medical Defense, in suits brought for alleged mal-practice, has brought many into the society, who never belonged before.

The work being done by the so-called Medical Freedom Bureau, which has a complete organization in the state, and some of the most talented speakers that money can buy, has aroused many to the importance of a closer union. Every irregular, every patent medicine vender, who was affected by the Pure Food and Drug Act, the followers of every "ism" on earth, are united and arrayed against the Regular Medical Profession today. The fight was begun on Dr. Wiley, and was aided by some of the most powerful political interests in this country. Under the guise of this Bureau of Medical Freedom, a fight is being made on the American Medical Association, and the Owen Bill, which creates a Department of Health. Contributions are made by all of the members of the so-called Bureau of Medical Freedom, at certain intervals, to keep up this fight, and it is one of the things that our society must do; prepare ourselves to meet this enemy that is trying to destroy us.

I would recommend that we endorse the Owen Bill. Also would recommend that our Committee on Legislation be instructed to see that we have a component committee at Topeka, at the next session of the Legislature, to look after Medical Legislation. Would further suggest that we interview the candidates for the Legislature of both political parties, and secure promises from them before election.

Since the last meeting twelve hundred fortyfour members have paid their dues, which is the largest paid up membership we have ever had.

The following is the financial statement for the year ending April 30, 1912:

Amount in Dr. Munn's hands May 1, 1911....	$5630.25	
Amount received from Dr. May on Journal acct	279.07	
Amount received from dues up to May 1, 1912.	2488.00	
Interest on Harper Loan.....	110.00	
Total.....		$8507.32
Paid out on general account.....	$1280.43	
Paid out on Journal account.....	1000.00	
Paid out on Medical Defense Fund.....	150.00	
Total.....		$2430.43

Balance in hands of treasurer.....		$6076.89

Respectfully,

CHAS. S. HUFFMAN, Secretary.

Moved and seconded that the report be received and turned over to the Auditing Committee. Carried.

TREASURER'S REPORT.

Mr. President and Fellows of the Kansas Medical Society:—I have the honor to submit the following report:

Balance on hand May 2, 1911.....	$5630.25	
Cash, Harper Loan Interest.....	110.00	
Cash received from your secretary.....	2767.07	
Total.....		$8507.32
Cash paid out general fund, per voucher.....	$2280.43	
Cash paid out Medical Defense Fund.....	150.00	
Total.....		$2430.43
Balance on hand May 1, 1912.....		$6076.89

Very respectfully,

L. H. MUNN, Treasurer.

President appoints auditing committee; Dr. W. E. Currie, Dr. A. D. Jones, Dr. H. B. Caffey. "This commiittee may look over the reports of the secretary, treasurer and editor."

Dr. Axtell calls for reports of standing committees.

DR. C. S. HUFFMAN.—"As chairman of the Committee on Scientific Work, in preparing this program, the question came up whether to make a symposium of it, or running subjects together pertaining to any one line of work. It was hard to get an expression out of the society. Some time ago we decided to make a program as this one now ready, and I have followed this plan. I would like to ask the President to call on delegates to give their ideas on this program."

DR. C. C. GODDARD.—"I think Dr. Huffman knows I have expressed myself on that already. The great trouble with the regular profession in society business is that they and the people are too far apart. The people of the Bureau of Medical Freedom, Chiropractics, etc., are in with the people. They canvass their subjects and urge their ideas on the people. We get up these programs, get together and have these papers and that is all right as far as it goes; they are all right for the doctors themselves, but the people that you are depending on for support, are drifting away. They have you classed in with a mystic business, and think you are trying to hide things from them, and that you are trying to

pull their leg. They think you are trying to pass laws for graft, and you cannot make them think anything else because you never get the people with you. They never hear papers explaining our reasons for making laws concerning public health. They cannot conceive of a man in business taking money out of his pocket. That is what the doctors are trying to do. This is so incomprehensive to the public that they cannot believe it. I remember a meeting we had at Concordia, a few years ago, one of the best meetings we ever had. Here there was an open meeting for the public, where papers were read and understood and appreciated by the public. Should the public come to hear the papers of this program, they could not understand one-tenth of what we have to say. It does not interest them. As I say, here we had an open meeting; the court house was full of men and women, there was music and addresses that the people understood.

Here the cause, prevention and treatment of tuberculosis was discussed, and ideas of isolation of contagious diseases discussed.

There are a large class of irregulars that are putting the idea into the heads of the people, that the regular medical profession is a trust. This Bureau of Medical Freedom believes in Christian Science, and all sorts of "isms" and cults. They say they are the people trying to save you from this trust.

As I started out to say, these programs are all right, for our meetings in this society, but with this plan you are not educating the people, or getting any closer to them. If we could have a few sessions for the public, you would make more friends, it would mean more support from the people. As to our law making body of the state, I will say if something is not done within the next few years, you will have no medical law. It was but the flipping of a coin that saved our present law at the last session. Simply an incident that kept it from being repealed entirely. At the next Legislature the people must wake up, or we are going to lose out. I know it to be a fact, that one man was to be paid $1,000.00 to get up and talk for the Chiropractics and the Bureau of Medical Freedom. It got just a little too hot for this fellow, and he was scared out. Medical men of Kansas are not paying any attention to politics, but the osteopaths were there at the last session. Two-thirds of the house were osteopaths, or in hearty sympathy with the Osteopaths. As Dr. Huffman has said, we must get into politics. At the last legislature we came mighty near having a law passed that would put men in as our competitors that had but sixty days training. 'I repeat it, my idea in regard to those programs is to provide for sessions that will interest the public. I may be wrong, but that is my idea."

DR. J. L. EVERHARDY.—"This has been tried by our county society at home, and that is, to arrange our meetings in sections, having one section surgical, and next evening have a section on internal medicine. I do not mean to suggest that the state society be divided in separate sections, but take two or three hours for internal medicine, then several hours for surgery, and get up rivalry in the different sections, and they might be better attended, and there might be an effort made to read better papers."

DR. H. B. CAFFEY.—"I have frequently expressed myself in regard to divided meetings or dividing the society into sections. I have corresponded with the secretary about that, and with the gentleman from Leavenworth, I agree that the better way would be to have a section on Internal Medicine, and one on Surgery, and arrange their meetings as he suggests. In addition, I would say, that some time should be devoted to the specialties, among which would be eye, ear ,nose and throat. I would say that each section should have its own chairman and secretary, and the chairman to preside at the meetings of his section. I think it is time to consider arranging our programs for these sectional meetings. It is hard for the secretary to arrange a symposium, unless he can get men to volunteer. Everyone is invited to write papers, and we get scattered subjects. The program is arranged nicely this year, and a wide range is covered. This plan would create more interest, and as Dr. Everhardy has said, 'there might be an effort made to read better papers'."

Moved and seconded that the House of Delegates adjourn until Thursday Morning, at 8 a. m., May 2nd. Motion carried, and meeting adjourned.

MEETING OF THE HOUSE OF DELEGATES.

Hutchinson, Kansas, May 2, 1912.

Meeting called to order. President J. T. Axtell in the chair. Chas. S. Huffman, secretary. Roll was called and a quorum was found to be present.

The following resolutions were adopted:

No. 1. Resolved, It is the sense of the Kansas Medical Society, that we should favor an enactment by the legislature, requesting the registration of trained nurses.

No. 2. Resolved, By the Kansas Medical Society, that we commend Dr. H. A. Dykes, secretary of the state board of registration and examination, for his untiring efforts in enforcing the law regulating the practice of medicine in this state.

The following memorial was sent to each of our representa-

tives in Congress. We, the Kansas Medical Society, again wish to express to our representatives in Congress, our endorsement of the Owen Bill, providing for a National Bureau of Public Health. Your support of it is urged, and every member of the society will watch with interest, your vote.

The following officers were elected for the ensuing year: President, Dr. Geo. M. Gray, of Kansas City; Vice-Presidents, Dr. H. G. Welsh, of Hutchinson; Dr. C. Klipple, of Hutchinson and Dr. G. A. Blasdel, of Garnett; Treasurer, Dr. L. H. Munn of Topeka.

The following councillors were elected:

1st District—Dr. C. W. Reynolds, Holton; 2nd District—Dr. C. C. Goddard, Leavenworth; 7th District—Dr. W. F. Sawhill, Concordia; 8th District—Dr. O. D. Walker, Salina; 9th District—Dr. C. S. Kenney, Norton.

The complete council now, is as follows:

1st District—Dr. C. W. Reynolds, term expires 1915. 2nd District—Dr. C. C. Goddard, term expires 1915. 3rd District—Dr. H. B. Caffey, term expires 1913. 4th District—Dr. W. E. McVey, term expires 1914. 5th District—Dr. W. E. Currie, term expires 1914. 6th District—Dr. A. D. Jones, term expires 1913. 7th District—Dr. W. F. Sawhill, term expires 1915. 8th District—Dr. O. D. Walker, term expires 1915. 9th District—Dr. C. S. Kenney, term expires 1915. 10th District—Dr. E. J. Beckner, term expires 1913. 11th District—Dr. J. A. Dillon, term expires 1913. 12th District—Dr. W. F. Fee, term expires 1913.

The House of Delegates instructed the Council to appropriate sufficient money to pay for a lobbyist at Topeka, to look after Medical Legislation, that may be considered this coming session.

The auditing committee submitted the following report, which was adopted:

We, the auditing committee, wish to submit the following report, that we have made a careful examination of the secretary and treasurer's report, and found them correct in every particular, there being a balance on hand May 1, 1912, of $6,076.89.

H. B. CAFFEY,
W. E. CURRIE, Auditing Committee.

House of Delegates instructed the Council to organize a society known as the Public Benefit Society, the purpose of this society being, to look after the interests of the profession in the matter of legislation. Motion was made that $1,000.00 be set aside and added to the Medical Defense Fund.

The Standing Committees are: Committee on Medical

Defense—Drs. W. E. McVey, O. D. Walker and W. F. Currie. Committee on Scientific Work—Drs. C. S. Huffman, O. D. Walker and M. T. Sudler. Committee on Public Policy and Legislation—Drs. G. M. Gray, C. S. Huffman, W. F. Bowen, J. F. Gsell and W. F. Sawhill.

Drs. W. E. McVey, O. D. Walker and C. E. Reynolds were appointed to investigate the organization of the Public Benefit Society, and report at the January meeting of the Council.

Dr. J. T. Axtell, Newton, was elected delegate to the A. M. A.

All of the council were elected associate editors of the Journal, and asked to assist the editor in the management of the Journal for the ensuing year.

Motion was made and passed that Dr. H. A. Dykes be reimbursed in the amount of $260.00, which he paid out for the prosecution of irregular practitioners. The council organized by electing Dr. Geo. M. Gray, Chairman and Dr. Chas. S. Huffman, Clerk.

Topeka was selected as the next meeting place.

Meeting adjourned.

CHAS. S. HUFFMAN, Secretary.

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SOCIETY NOTES.

1st District, C. W. Reynolds, councillor, Holton—No report.

2nd District, C. C. Goddard, councillor, Leavenworth.—No report.

3rd District, H. B. Caffey, councillor, Pittsburg.—No report.

4th District, W. E. McVey, councillor, Topeka:

The Shawnee County Medical Society has adjourned for the summer. The next meeting will be held the first monday in September.

5th District, W. E. Currie, councillor, Sterling:

Following is the program of the Harvey County Medical Society for July:

"VALVULAR HEART DISEASE."

Dr. G. D. Bennett,—"Etiology and Pathology." Discussion, Dr. M. L. White.

Dr. D. G. Buley,—"Differential Diagnosis." Discussion, Dr. R. H. Hertzler.

Dr. E. E. Wuttke,—"Treatment of Aortic and Mitral Lesions." Discussion, Dr. J. M. Sutton.

F. L. ABBEY, Secretary.

The Butler County Medical Society held a meeting at Augusta, June 20th. The following program was given:

Paper—The Use of Calcium Chloride as a Prophylactic Against Haemorrhage in Typhoid Fever. Dr. N. E. Wilson, Douglass. Discussion, led by Dr. F. E. Dillenbeck, El Dorado.

Paper—Eclampsia. Dr. Wm. McKinney, Latham. Discussion, led by Dr. Anna Perkins, El Dorado.

Paper—Dr. O. M. Lightner. Discussion led by Dr. R. B. Earp, of El Dorado.

Paper—P. H. Bernsdorf, Benton. "The Relation of the Physicians to the Public." Discussion, led by Dr. C. E. Hunt, Eldorado.

Supper for Physicians and their Ladies.

Mass Meeting in Pavillion, in City Park, 8 o'clock, p. m.

Address by Dr. C. S. Kenney, of Norton, Kansas.

J. R. M'CLUGGAGE, Secretary-Treasurer

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The Stafford County Medical Society convened at this place on the 12th inst., with Dr. J. T. Scott, President, in the chair, and a fair representation of the members present. After the reading of the minutes of the previous meeting, and other preliminaries, notice was taken of the death of our lamented brother, Dr. F. S. O'Flyng of Seward, Kansas, which occurred April 30, 1912.

Whereupon a committee on resolutions was appointed, which committee reported as follows.:

In loving remembrance of our late brother physician, Dr. F. S. O'Flyng, who departed this life, April 30, 1912.

Whereas, The last call has been answered, removing from our midst our beloved brother, Dr. F. S. O'Flyng, we are reminded that we have parted company with a brother physician who was endowed with those qualities which are essential to an ideal Christian character in the physician. He was a man of even temper, and was kind and polite to all alike. A man of pronounced religious temperament, he stood for the highest type of citizenship both in state and in society. His ability and worth were not confined to his chosen profession of medicine, as he devoted considerable time to the study of music, in which field he won distinction by composing and setting to music several popular songs. Therefore, be it

Resolved, First, That while we bow to the will of Him who doeth all things well, we deplore the loss of our brother, physician, friend and neighbor.

Second, That the medical profession of our state has lost a faithful member, and his family a kind father and brother.

Third, That the heartfelt sympathy of each member of our County Medical Society be tendered his bereaved relatives.

Fourth, That a copy of these resolutions be printed in our County paper, and that copies be furnished the sorrowing relatives.

M. M. HART,
Signed J. J. TRETBAR,
W. L. BOST, Committee.

The society was then highly entertained by a paper by Dr. F. W. Tretbar, on the "Vaccine Treatment of Typhoid Fever," which was followed by a very lively discussion. The social features of our meetings are always an important part of our program.

CYRUS WESLEY, Secretary.

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6th District, Arch D. Jones, councillor, Wichita.—No report.

7th District, W. F. Sawhill, councillor, Concordia:

The Cloud County Medical Society held its regular meeting in the Commercial Club rooms, Concordia, on the evening of Tuesday, June 18th. There were fifteen physicians present, this being the largest attendance this year. There are now twenty-two members of this organization in Cloud county.

Dr. M. L. Belot of Aurora, presented a paper entitled, "Diagnosis and Treatment of Exophthalmic Goiter," and gave an excellent resume of all the latest information of this comparatively common disease. The paper was exhaustively discussed by Drs. Kimble, Sawhill, Weaver, Pigman and Robertson.

Dr. C. S. Kenney of Norton, deputy state health officer, gave an extended talk on "The Tuberculosis Notification Law—Its Object and the Difficulties in its Enforcement." At the close he was asked many questions and his talk was highly appreciated by the physicians of Cloud county.

After transacting some business, the society adjourned to meet again in about six weeks.

E. N. ROBERTSON, Secretary.

8th District, O. D. Walker, councillor, Salina.—No report.

9th District, C. S. Kenney, councillor, Norton.—No report.

10th District, E. J. Beckner, councillor, Seldon.—No report

11th District, J. A. Dillon, councillor, Larned.—No report.

12th District, W. F. Fee, councillor, Meade.—No report.

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NEWS NOTES

The annual meeting of the Medical Association of the Southwest will be held at Hot Springs, Arkansas, October 8-16th. Dr. J. F. Binnie, of Kansas City, Mo., will deliver the oration on surgery and Dr. W. M. Graves of Galveston, Texas, on general medicine

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Dr. Geo. S. Wilcox of Freeport, Kansas, and Miss Alice Austella Snooks, head nurse of the Keller Hospital of Ironton, Ohio., were married April 3rd.

Dr. C. A. Lilly of Atchinson, Kansas, sailed June 8th, 1912, for Europe, where he will spend several months in hospitals of London and Vienna studying surgery.

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Dr. C. L. Zugg, of Kansas City, Kansas, is spending three months in Chicago, doing post work on the eye, ear, nose and throat. He will return October 1st.

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Dr. Samuel W. Dunlavy and Mrs. Flossy Lippy of Cherryvale, Kansas were married May 26th.

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At the annual meeting of the State Board of Health, Dr. H. L. Aldrich, Caney, was elected president; Dr. V. C. Eddy, Colby, vice-president, and Dr. S. J. Crumbine, Topeka, secretary, (re-elected for the eighth consecutive term.) Dr. W. D. Hunt, Emporia, has been appointed a member of the State Board of Health. Dr. C. J. Simmons, Lawrence, has been re-appointed a member of the State Board of Medical Examination and Registration. Dr. Henry A. Dykes, Lebanon, has been re-appointed secretary of the State Board of Medical Examination and Registration.

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Dr. Fred A. Forney has succeeded Dr. G. R. Gage, resigned, as chairman of the Hutchinson Board of Health.

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Electics Endorse Owen Bill.—At the forty-second annual session of the Kansas State Electic Medical Society, resolutions were adopted endorsing the Owen Bill now before Congress.

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OBITUARY.

Charles F. Leslie, M. D., a graduate of the Medical School of Maine, 1874, a practitioner of Clyde, Kansas, for twenty-seven years, member of the A. M. A., surgeon U. P. and M. P. railroads, president of board of U. S. examining surgeons, Concordia, Kansas; ex-president of Cloud county medical society, died suddenly at his home the morning of May 30, 1912, age 65, of angina pectoris.

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John A. Wood, M. D., College of Physicians and Surgeons, Keokuk, Ia., 1858; a pioneer physician of Coffeyville, Kan; died at the home of his daughter in that city, May 23, from heart disease, aged 78.

IN MEMORIAM.

Dr. Richard E. McVey.

Doctor Richard E. McVey was born in Alton, Illinois, November 19, 1828, and died in Topeka, Kansas, May 23, 1912.

Doctor McVey was graduated from Rush Medical College in 1861, and entered at once upon the general practice of medicine at Waverly, Illinois. He continued at this location, doing an extensive practice, until 1885, when he removed to Topeka, and established himself in the Kansas Capital. Here he at once identified himself with every movement looking to the advancement of the community and of his profession. He was one of the founders of the Kansas Medical College, and remained an active and zealous member of its faculty till his death. He was a member of the Shawnee County Medical Society and of several other medical organizations, and retained an eager interest in their proceedings to the last. He was a regular attendant at the meetings of his County Society, and was always ready to contribute to the program. Only a week or two before his death he presented a scholarly paper on "Herpes."

Doctor McVey, although an octogenarian, led a very active professional life to the very last. He loved his vocation, and prided himself on his well sustained energies. He was little inclined to accept the furloughs that the advancing years might naturally suggest. He made no concession to old age, but continued to consider himself young. Indeed, he was young in spirit, to the end. Men of his age are apt to retire from active life and to put their faces toward the past in profitless retrospection. But, Doctor McVey kept his face and mind toward the future, with an eager outlook on the great unexplored field before him.

He was always a student. He was familiar with the classics of literature and of science. He kept himself in fresh touch with these subjects, and with medical advancement, by constantly buying and reading the most recent books and periodicals, and few men were better informed or more abreast with the times than was he.

He had an inquisitive mind—the mind of a scientist. While he was eager to learn the new doctrines of philosophy and of medicine, he was deliberate about accepting a new pronouncement. He submitted every champion of a new theory to an acute and

searching cross-examination. He did this, not in a spirit of disputation, but rather to exercise a true scientific habit of mind in himself and others.

He loved the young, and enjoyed association with youth. He took delight in his medical class work, and was beloved by the many students who have been under his teaching. By his fondness for the young he manifested his own surviving youth, and maintained the same. His face and eye were always bright and eager, illumined with hope and cheer and aspiration and loving-kindness. These are the certain badges of youth, no matter how gray the hair or how faltering the foot-steps.

Doctor McVey will be sorely missed by the many who were privileged to know him well, whether laymen or colleagues. To all such he endeared himself. Indeed, the absence of his kindly face and genial personality will be a conscious loss to very many, who, perhaps, did not fully appreciate their quality and value before.

His passing was sudden and free from pain and suffering. There was no lingering illness. No weary days of waiting in hushed and darkened room for an inevitable event. No agonizing farewells. He went peacefully to his long rest.

"Like one who wraps the drapery of his couch
About him, and lies down to pleasant dreams."

O. P. DAVIS.

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REVEIWS.

Hydrophobia, (Rabies.)—A case of hydrophobia in a child 3 years old is reported by J. G. Cumming, Ann Arbor, Mich. (Journal A. M. A., May 18), who also gives a good description of the disease and its diagnosis. After mentioning the popular errors in regard to the dread of water by rabid animals and the special dangers of the disease in hot weather, he says it should not be confused with the disease commonly called fits in dogs, which lasts only from thirty minutes to two hours, as against six or seven days in rabies. Rabid dogs seldom foam at the mouth; they may drool from deglutitory paralysis, but a dog with fits forths profusely. A rabid dog never recovers, as is often the case with dogs with fits. The latter disease should not be confused with rabies if the histories

are taken into account and the Negri bodies are absent. The specific virus has its normal habitat in the nervous system and is only temporarily virulent anywhere else. It is readily destroyed by heat and drying, and when introduced into a wound it must come in contact with a broken nerve trunk to survive and reproduce itself. It is usually spread by dogs, 90 per cent of cases being due to their bites. Other animals are liable to it and many convey it. The disease may develop, however, simply from a rabid dog licking a scratch or from its saliva coming in contact in any way with an open wound. In the paralytic stage of the disease the dog is not aggressive, but this is not so common as the furious delirium which usually appears early and in which it is liable to attack anything in its way. Death results from complete paralysis, usually in from two to seven days after the first appearance of the symptoms. In the laboratory at Ann Arbor they have observed the virus to the third and fourth generation, verifying the diagnosis by laboratory tests. All the dogs of the fourth generation of rabies were killed but one, which the owner wished to keep to assure himself that it was mad. After an incubation period of four weeks, it also become rabid, and not being properly restrained, caused one human death from the disease.

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Gall-Stones.—Dr. W. J. Mayo controverts the old idea of gall-stones without symptoms, and contends that the per cent of gall-stones estimated by some good authorities is incorrect. He believes that 5-10 per cent in all cases is more correct and that 5 to 8 per cent for women and from 2 to 4 per cent for men after 50 years of age is nearer the truth. Dr. Mayo is of the opinion that the theory of innocent gall-stones is an unfortunate contention and subjects the patient to a dangerous risk, among which is the risk of cancer. In his cases 2.25 per cent had carcinoma of the gall-bladder.—Journal A. M. A., April 8.

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For Sale.—1 X-ray coil, Scheidel; 1 rheostat, (wall-plate); 1 high frequency apparatus; 1 tube stand.—Mrs. John Troutman, 902 N. 7th St., Kansas City, Kansas.

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For Sale.—A $5,000 practice with 10-room modern house in town of 500 in prosperous north central Kansas; competition light; fine climate and roads; this is a good chance for a worker; I wish to retire; price $4,500, $2,500 cash; do not write unless you mean business and have the money. E. M. B. % Journal.

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ANTI-TUBERCULOSIS FIGHT AND SOME FIELD NOTES.

JOHN J. SIPPY, M. D., Belle Plaine, Kansas.

Read before the Kansas Medical Society, May 1, 1912.

Two weeks ago the world was horrified by the news of the Titanic disaster, when 1600 persons were drowned in the icy waters of the Atlantic.

Today a congressional inquiry sits in session to determine the responsibility of this accident, and a news item in today's paper announces that it's work will not be completed for six weeks and the expense of the sitting will reach into thousands of dollars. And to what end? Simply to prevent a repetition of such accidents, and to furnish means of escape in case it should again occur. Newspaper columns are full of bitter denunciation of every member of the steam-ship company concerned, and the future cost of preventive measures will reach into millions of dollars. All because of the lesson which the loss of 1600 lives has cost. It has never occurred but a few times in all the history of navigation and it may never occur again for a decade.

I have no wish to depreciate the motives with which certain of our public men and the newspapers have been inspired in their attempts to pass preventive measures, for they are proper, but why the need of hysteria in this particular instance? Doubtless 1600 lives are valuable, and I surmise that many of you, hardened as you are to the passing of the life to death, were dumb for a considerable period after reading the headlines which announced the disaster. And still, gentlemen, I can come before you and the Kansas public, and announce to you that the loss of life is duplicated in this state every year, by a single preventable disease, and the announcement hardly produces a ripple on your current of thought.

Sixteen hundred deaths by the sinking of an ocean liner—

1600 deaths in Kansas from tuberculosis, and both preventable. Yet the one is only a single instance—the other a continuous annual toll, growing larger year by year.

Why newspaper columns, congressional investigations and the expenditure of thousands on the one, and not on the other? Why columns of invective censure on steamship officials and employes on the one hand, and total irresponsibility of anyone for the other? Who is responsible for these 1600 deaths in Kansas? Am I, or are you?

A glimmering of the fact that consumption is an infectious, communciable disease is beginning to dawn on the public mind, and I even have hopes that it will soon be a matter of common knowledge among the majority of the members of the medical profession. Some of you may resent this reflection on the intelligence of the Kansas fraternity, but it is made after due consideration and after a visiting experience of six months among what might be termed a representative mass of the profession of this state. And with all due respect and the high regard which I have for the general professional and educational qualities of the average Kansas practitioner, I still charge him with being derelict, conscienceless in his sense of duty to his clientele and the people of the State in which he lives. when it comes to his stand in this fight against the "great white plague." How and why?

In the first place Kansas has a compulsory notification law which provides that every case of tuberculosis coming within the knowledge of any physician must be reported by that physician to the nearest health office having jurisdiction. Immediately on receipt of that report the health officer mails to that physician a blank asking the physician to take certain procedures and precautions on the premises of the patient, and to give that patient certain sanitary instructions as to the care of his room and person and such other measures as may be necessary to prevent spread of this infection among the patient's family, friends, and the public. If the physician is willing and able to give these instructions, will proceed to do so and will certify to the health officer that he has done so, he is entitled to a fee of $1.00 from the city or county general fund. If he is unable and unwilling to attend to these details, he should so notify the health officer, whose duty it is then to see to them himself, and for which the health officer is entitled to the fee.

After the death, removal or recovery of a case of tuberculosis, the premises of the patient must undergo thorough cleansing, fumigation and disinfection, under the direction of the health

officer, and at public expense, unless the family of the patient, or the householder wish to bear this expense themselves, the event of other death removal or recovery, the health officer must be notified promptly, and a penalty is provided for failure to do so.

The law provides for secrecy in keeping of all tuberculosis records, and they are not open for inspection of general public, as in the case of other contagious disease records.

The State Board of Health has attempted to employ every facility for assisting the individual physicians in the operation of the law. Cards and blanks have been furnished for all reports, and made as brief as possible for the obtaining of all necessary data bearing on each case. In every case where the diagnosis is unmistakable or in which the tubercle baccilli has been demonstrated in the operation, sputum cups and supplies will be furnished on requisition of the physician, to the patient free of charge, with the exception that carriage charges are to be paid by the patient.

A State bacteriologist is ready and willing to examine all specimens of sputa to determine presence of the tubercle bacilli, in doubtful cases and to make these examinations free of charge. Mailing tubes for these specimens will be furnished by all health officers on application.

Theoretically the law is ideal. A few details might be varied, and should appropriations be sufficient all the various little charges and expenses for delivery of supplies to the individual might be eliminated, and the fee to physicians for his sanitary supervision of every case might be increased. But these are details and should be, in his line of duty, no excuse for any conscientious man to fail to observe the law and make it a success. And yet, though the law has been in effect some three years, it is not meeting with the observance which it and it's cause demands, and it is a daily occurrence to receive death certificates of case after case of tuberculosis for which no previous notification has been filed by the attending physician. Why should he not comply with the law? I have stated that the average practitioner has not yet fully realized that the disease is infectious and contagious, and I have no reason to change that statement. If he does, he has no reason for his neglect of the law, unless he is willing to have challenged his ability for diagnosis. Many physicians assert they have no tubercular cases, and while some of them may be correct in the assertion, yet in it's incipiency no disease is so seldom recognized and diagnosed, and those physicians who wait for the cough, the expectoration, the night sweats, and that train of symptoms by which even the patient comes to recognize his condition—to make

a diagnosis, will have charged on their debits on the books of the recording angel, many funerals, many widows and orphans, and many fresh victims of the disease through their neglect of recognition and preventive measures.

Early diagnosis is essential to successful treatment, and under a regime of fresh air, rest and proper nourishment, when given early, 75% of all cases recover. Some good sanatoria announce a percentage of cures as high as 90%. It is estimated by best authorities that every case before it's termination infects from four to ten other persons. So aside from treatment. early diagnosis, and the early inculcation of sanitary precautions are necessary then for the protection of relatives and friends. Why fail to extend them that protection?

Every physician has a salve for his own conscience in excusing his neglect of the law. The principal formulae are these: First, he doesn't care to treat these cases, for treatment is very unsatisfactory, and patients are usually unable to make financial return, for tuberculosis seems to be one of the "blessings of the poor." Second, he fears to offend the patient and family by making a repeal, and thereby loses the patient. Third, he considers the law all poppy-cock anyhow, and demands services from him which are nuisances, and for which he is inadequately recompensed.

I have answered the first by reminding him of the necessity of early diagnosis and treatment. both for protection of patient and friends, and his duty which he owes the public regardless of compensation. To the second, I have only to remind him that the utmost secrecy surrounds the patient if he so wishes. Besides, there is no more reason for the patient to be offended in cases of tuberculosis than in scarlet fever or small pox, in neither of which the physician feels any hesitancy in reporting, which accentuates the fact that the difference is only one of education which every physician owes the public. To the third, that of inadequate compensation, I admit ground of complaint, but one for which the Board of Health is in no wise responsible, and which it would very much like to remedy, were it possible for it to convince legislators of the fact. A cause in which the physicians themselves must manifest an interest heretofore not manifested by them—neglect again, for which they alone are responsible—and which should not deter them from giving the Board of Health unrestricted co-operation.

In brief, the facts are these—whatever opinion the public may hold of the physician when in good health—in times of sickness it looks to the profession for advice and instruction, and the man who withholds it for a compensation of dollars and cents in-

stead of public gratitude, has mistaken his calling. The Board of Health has no interest in this class of cases beyond seeing that each case is properly restricted from a sanitary standpoint—preferably by the medical attendant, and in event of his failure, by the members of the Board. But the Board must have this assurance in every case and it cannot feel so without the proper reports, which the law demands of the physician. The Board prefers voluntary co-operation of the physician. How many of you will compel it to enforce the penalties of the law?

Whether the patient observes the sanitary restrictions placed upon him is a matter of further concern to the Board. His failure to do so may be through one of three reasons—faulty instruction by the medical attendant—ignorance and inability to properly appreciate these instructions, or wilful neglect and violation. The law is based on the supposition that every patient is intelligent and willing to co-operate with the attending phvsician and the provisions of the law, but for reasons mentioned, this is the weakness of the law, for the majority of patients are violators in one of these respects. The remedy, and my own personal belief is that the ultimate result will be the absolute quarantine of every case, or at least the careless ones, before we finally rid our civilization of the dread disease.

Some of you, who are careful law observers, may take offense at the censure I am placing on the medical profession, but I assure you I have not made any charge which I have not substantiated by investigation. That a large per cent of the carelessness in observing the provisions of the compulsory notification law is due to thoughtlessness, I will admit, and it is with the idea of compelling you to think that I have written as I have. With you the reporting of a case is only an incident of routine, but to the patient, his family or his friends, it may be a life or several lives. In urging you to observance I do so, not holding the penalties of the law before you as a punishment for failure, but rather to bring to your mind your forgotten duties to your patient, his family and the public, and your patriotism to the state, as a public spirited citizen. Will you prove your worth as one?

THE RIGHTS OF A CHILD.

DR. J. R. SCOTT, Newton, Kansas.

Read before the Kansas Medical Society, May 1, 1912.

The State requires of every citizen that he be law-abiding, that he contribute to the general welfare of his community and that he bear his proportion of the expenses of the government of which he is a part.

In view of these facts every child has or ought to have the right to demand of the state the opportunity to grow and develop, both mentally and physically, in a manner that will make it possible to meet the requirements of the state when he shall have arrived at maturity.

I do not intend to enter into discussion of prenatal tendencies, neither do I care to discuss that much abused and thread-bare subject, hereditary influence during gestation. There may be and doubtless are forces working for and against the child's welfare prior to his entry into this world, but except as these forces determine the physical condition of his parents the theories advanced in regard to parental influences during gestation, are too nebulous for serious consideration. The things that determine a child's fitness to fill his niche in the world are largely those forces which surround him after birth. Environment plays so large a part and hereditary influence during gestation so small a share in shaping and moulding into maturity a human life that it can be left out of consideration.

Certain qualities of mind and heart are the result of inheritance, but they are potential qualities only to be stirred into activity, by contact with events and association with other minds. Children born into educated and refined homes are usually better equipped for life's vicissitudes, but here it is largely a matter of better surroundings and better training rather than willing that certain qualities shall appear in the offspring. Education is not inherited.

The physical stature cannot be determined by deliberate intention of the parents, and likewise the mental endowments rests on other than the mental state or activity of the mind of the mother during the period of gestation. The question that concerns us and that particularly concerns the child, is what opportunities will be his? Will he be aided to develop normally the highest qualities of body, mind and soul compatible with his natural en-

dowment, or will he be hampered and fenced about with obstacles to such an attainment?

Our fathers fought a long and bloody war and endured hardships that we might worship God as our consciences dictated and enjoy certain inalienable rights among which" are life, liberty and the pursuit of happiness." Many sacrifices were made and many gave their lives that this nation might be born, yet greater is the sacrifice of the children in blasted hopes and blighted lives, because the children are not, physically or mentally equal to the task of forcing us to recognize their right to participate in these blessings. There are nearly two million children under sixteen years of age who are forced into wage earning vocations. Deprived of their childhood and compelled to labor under conditions that will prevent normal physical growth and that effect the higher functions even more disastrously. No child can stand the nervous strain incident to factory life and come out unharmed. Almost can it be said of children forced to work long hours, particularly in shop and factory, "who enters here leaves hope behind." A child may be early trained to some useful occupation without injury, but he needs time for relaxation, his hours must be short and his task suited to his years. A child needs time for himself; time to put into operation his own plans and purposes; time wherein he may develop his own initiative; time in which to cultivate qualities of brain and soul. He must be surrounded by conditions that will expand his imagination, for out of these will grow the foresight and purpose that in after life will conceive and plan the wonderful achievements of the future. And back of it all must be the brain that is to carry into effect the imaginings of a healthy active brain. What one is, is the result of early environments, college training and association in later life can only build on the foundation already laid.

Much has been said of late about the defects of our educational system and it doubtless is defective. The misfits we see daily are to a considerable extent the result of attempting to give each the same dose regardless of his abilities or natural inclination. A system that will give to each child the largest possible mental development and manual dexterity, will add much to the sum total of human progress and individual contentment.

Good pictures are now so cheap that it seems almost criminal to allow children to become familar with the miserable blotches that pass for pictures and which violate every law of harmony and taste. Books of history and biography are potent in shaping the lives of children, who are naturally hero worshipers. There are

many art galleries and circulating libraries, yet these are not accessible to every child and it seems to me that every school house ought to be a center where every child shall come in daily contact with a few good books and a few pictures really worth the name.

The old world say we on this side, lack appreciation of music. To a large extent the charge is true. Too often children grow to maturity with little idea of music but popular airs and rag-time or the fearful screeching that passes for music in the popular nickle theatres. These places have a place in our civilization, but as they are largely patronized by children the music as well as the pictures need censuring.

The conditions of which I have been speaking, it is our duty as citizens to improve in every possible way, but there are certain physical obstacles to a child's proper development in which we as physicians, stand in special relation. While the relation of the physician to the families under his care is not as intimate as it was in the last generation, we still have a large place in the affections of our patrons.

There are the questions of proper food and clothing, conditions necessary to secure for the child normal rest, the necessity of guarding the child from infections, in short the general conditions that surround the home life of the child, that if taken up at our instance and discussed with the mother, might do much to re-establish the confidential relation that has been passing with the passing years. People are looking less and less to their physician for help in solving these problems, and yet no other source of information ought to be as reliable or more sought for. Perhaps, the more commercial aspect we assume toward our patrons has much to do with the passing of the family doctor.

Then there are the special conditions within the child, faults in his physical make-up, and which if un-corrected, materially interfere with the child's proper development. Eye strain is not a myth, the symptoms are well defined and its results far reaching, and often very deleterious to the growing child. Excessive contractions of the ciliary muscles requires extra energy, and often children are unable to expend the extra energy, and organs remote from the eyes suffer as well as general nutrition, Myopia is an acquired defect brought about by excessive use of the eyes. The child may become a myope from eye strain or if the structures of the ball do not give way to the continual tug of the ciliary muscle, the continued extra energy expended exhausts the individual and he breaks in his school years and manifests numerous neurasthenic symptoms which oftentimes follow him through life and

decreases his efficiency in the world. Besides there is a growing belief that cataract of advanced years is the result of eye strain in early life. Many children have defective eyes, and eye defects are responsible for their share of physical disability and retarded mental action.

The tonsil has of late years been charged with many crimes against sound physical health. Perhaps in some quarters the indictment is too severe, but no one who has carefully observed children before and after tonsillectomies can doubt the fact that in a considerable degree a true bill is found against the tonsil and that it must be pronounced guilty of impairing the health and endangering normal development.

One would think enough had been said about adenoids, and yet I think more will be necessary before all awake to the fact that adenoids are always deleterious and often a direct menace to life. Aside from the interference with breathing and the consequent stunted physical and mental development, and the facial deformity occasioned by mouth breathing, adenoids if not the excitant are the cause of nearly all middle ear troubles. Now, if one will remember that practically all deafness is the result of middle ear inflammation, he can readily see the handicap that adenoids put on the individual, So constant is the relation of adenoids to middle ear diseases, that in almost every case of double discharge from the ears a diagnosis of adenoids can safely be made. Deafness greatly interferes with one's ability to earn a livelihood as well as acting as a bar to his social enjoyment.

It is preventable in fully ninety per cent of cases, if prompt and energetic measures are instituted, when earache occurs the drum should be promptly incised, to wait until the pressure within has caused bulging of the drum-head is to wait until the antrum is also affected. The pain indicates swelling and pressure, and probably fluid. If no fluid exists, no harm results from the incision, while great damage may result from delay. The mastoid antrum is diseased in every case where pus forms in the middle ear and remains for any time under pressure. The lining membrane there is less able to resist infection than any other part, and in the majority of cases becomes diseased before the drum will rupture spontaneously. If the drainage is good the antrum will be restored and the discharge will disappear, if not, foci of infection will remain to kindle into new attacks or continue the discharge indefinitely, a menace to hearing and often to life. There is no more excuse for allowing a discharging ear to go, than there is for the surgeon to temporize in a case of chronic relapsing appen-

dicitis. An early operation on the mastoid eradicates the disease, prevents deafness and intra-cranial complications and is devoid of a mortality rate.

The method of treatment as well as the pathology of deafness will have to be revised in the next few years. As in other lines of medicine, preventive measures are the better, but many cases of deafness are amenable to treatment, when the right measures are employed.

All these physical defects, as well as unfavorable surroundings, do much toward producing the incompetent and vicious. The child has a right to demand a favorable environment, and relief from physical defects, when relief is possible. The parents are the natural guardians of their children, but it is the duty of the state to hold the guardians to a strict accountability, and if they will not provide the necessary environment, and care for their wards, then the state ought to insist that it be done, for it is wrong to allow the children to suffer because of the ignorance or neglect of their parents.

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SURGICAL TREATMENT OF HALLUX VALGUS, ASSOCIATED WITH BUNION.

DR. J. L. GROVE, Newton, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

The multiplicity of medical bunion cures constantly exploited and exploded, the application of plaster, pad and iron harness and their constant failure to ever approach a cure or even give relief from pain, leads me to a belief that the patient suffering from hallux Valgus with its constant companion, the bunion, must look to surgery for whatever of relief he may expect to secure.

The relief of hallux valgus could hardly be classed in surgical significance with work in the abdomen, yet the additional duty imposed on the surgeon of producing a cosmetic as well as a functional result, together with the relief of intense pain, makes the operation one of importance.

Anatomy and Etiology.—Civilization and her attendent restraint bear a most important causal relation to hallux valgus. The shoe with narrow tip and a trifle short deviates the great toe from its natural axis, which is through the center of the heel, to an angle of from thirty to ninety degrees. This angulation, after a time is augmented by the contraction of the extensor proprius hallucis tendon which has no means of retaining its natural posi-

tion over the joint and becomes easily displaced to the outer side of the joint area. The extreme French heel with its tendency to throw the foot forward in the shoe has much to do with the production of the deformity, hallux valgus. It may be a matter of consolation to the bunion sufferer to know that his more fortunate fellow with the short great and the longer second toe is possibly not so far removed from the monkey tribe as he. Darwin, in his classic "Descent of Man" states with authority that the primitive feet was used to grasp and hold objects and the great toe was set somewhat back, used much in the same manner as the thumb. This anatomical relation precludes any danger of the deformity, hallux valgus. Once the prominence of the metatarso-phalangeal articulation is established it is only a matter of a short time until the continued pressure of the shoe will produce the synovitis and thickening of the bursa, together with the inflammation, the true bunion. Anatomically the metatarso-phalangeal joint has little or no bony protection from either the deformity varus or valgus, as this joint admits of rather free adduction and abduction. This concavity of the first phalanx being so shallow and its articular surface being less in area than the head of the metatarsus, is another of the factors predisposing to hallux valgus. The first attachment of the lateral ligament to the phalanx and its constant motion over the head of the metatarsus makes it necessary that the inner coat should be lined with synovial membrane, and such is the case, the value of this anatomical fact will be demonstrated in the technique.

The operations, suggested for hallux valgus have been many and varied. One, complete resection of the metatarso-phalangeal articulation, operation of Reverdin; another resection of the phalangeal articulation and removal of a V shaped section behind the head of the metatarsus. Operation suggested by Kellar; still another,osteotomy just posterior to the metatarsal-head with correction of the deformity. Operation suggested by Young.

All the above have been to a degree successful in the hands of the general surgeon, however, the operation which this paper outlines and which technique the writer believes has many advantages over those mentioned above has been credited to Dr. Charles H. Mayo.

Technique.—The preparation of the patient should be thorough. The feet should be scrubbed and softened with soap poultice. Later sterilization in the usual manner. A U shaped incision base upward is made on the inner side of the metatarso-phalangeal joint. This incision only through the skin. The skin

flap is then dissected free from the underlying bursal tissue. Another curved incision is now made down upon the joint, to the periosteum, its base being toward the phalanx to which it is anatomically so closely attached. This flap is found to be lined with synovial membrane. After uncovering, the metatarsal head of the bone is removed with heavy bone forceps, then smoothed with Rongeur forceps. The bursal flap is now tucked in between the cut surface of the metatarsus and the head of the phalanx, thus placing synvoial lined surface of the flap to the synovial lined articulating surface of the phalanx. This step insures as a final result a useful movable joint. The flap is held in place with two or three cat-gut sutures. The skin flap is next punctured at its base and a fold of gutta-percha tissue inserted for drainage.

The skin incision is now closed with a lock stitch of cat-gut or horse hair. A few layers of gauze over the incision and a pad between the great and second toe to insure over correction constitutes the dressing. Over the entire foot is placed a thin layer of cotton and a light plaster cast which as soon as dry allows a window to be cut over the site of operation, so that dressings can be easily changed when necessary and drainage removed.

The after treatment of these cases is simple, ten days to two weeks in bed rids the feet of the swelling incident to the incision. Following this period a week on crutches with the feet still in the casts, the balance of convalescence in large easy fitting shoes with advice to patient fitting healing of an ordinary bone lesion. Results are uniformly gratifying. Motion is nearly perfect, correction of unsightly deformity, a freedom from pain in walking or standing, and correction of the metatarso-phalangeal angle which practically always prevents a recurrence. As the sesamoid bones and cushion beneath are not disturbed the final result is a bearing surface functionally perfect.

Photographic and X-ray illustrations.

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MEDICAL EDUCATION, PROFESSIONAL AND LAY.

DR. W. A. KLINGBERG, Elmo, Kansas.

Read before the Golden Belt Medical Society, Enterprise, Kansas, July 11, 1912.

Much has been thought and written on this subject, and yet the subject has not been decided satisfactorily to the general practitioner. The subject is not yet exhausted.

Efficiency is the great desideratum in all occupations and professions, but more especially in ours, because on the competency of the profession, depends the health of the community, and so the efficiency of the state.

The German Army, considered the most proficient in the world, does not consider a soldier trained after he has served and completed his three year's course of training; but the soldiers are required to take a six week's course of additional training each year, so that they may become and remain familiar with all new army tactics, field work and new inventions in arms of the past year.

If this is considered necessary in the army, I think it would not be asking too much of each member of the profession to take at least a six week's post-graduate course in our best hospitals and schools, in order that we may attain and remain at our highest efficiency.

Now there is some question how this highest efficiency may be attained, and I shall not discuss this subject at length, but suffice it to say that I believe all theoretical teaching should be avoided, and the whole time spent in mastering those things that will be of vital importance in our daily work.

Of what then may the work essentially consist? Writing from the general practitioner's point of view, I would say that one should have an efficient working knowledge of the latest and best laboratory methods.

One should know the practical methods and how to apply them. Those complicated methods, which the general practitioner can not apply should not be required, but most of us can master the new laboratory methods in pathology and bacteriology.

In this six week's course, we can master new methods of diagnosis, and the essentials of the most up-to-date treatment of diseases. Our knowledge of the dynamic action of drugs needs strengthening, and I think we would be much better off, if at least half of the Pharmacopœia were relegated to oblivion, and if we had a working knowledge of those drugs only, which have proved their curative power. Let us let the pharmacologist decide for us which drugs we can with benefit, employ.

When we realize that we can know but an infinitesimal part of what is to be known in medicine, we see how necessary it is to devote all our energies to the really important. If Dr. Elliott can gleam from the past and place on a five foot shelf a liberal education, we may see how we could curtail our reading matter.

The wisest of men have said, "Of making of books there is no end, and much study is a weariness of the flesh." When one has

mastered a modern system of medicine, he has about all that he can glean from all the systems written, and he can hardly afford to peruse all books written today. Indeed, one would be pleased to do so, but how much time would one have then for his practical work?

I wish to make a plea today for a system whereby the general practitioner, he of limited means, can keep well in the lime-light of the profession, and here is my suggestion: When a young man graduates, he has mastered up -to-date books, it should not be necessary for him to purchase all the new books written and master them. He can not do it, but he can assimulate all the good there is in the new, if some one of authority will glean it for him from the world's writings.

I like the 'Year Books' published in Chicago. I like the Medical Annuals, but they contain simply a resume of what has been written in the past year, and much that is written may not stand the test of time. Let us engage such master minds as Frank Billings of Chicago, to name the important things of the past year in general medicine.

Let John Murphy enumerate the new findings in surgery, and others of equal renown in the several specialities and then it will be possible for all of us to know that which will help us to be competent life savers.

I am but a young man in medicine, yet most of my books that are ten years old are valueless, but if each year there would be published in the journal of the "American Medical Association" in concise form, what the master minds had found of permanent value, our expenses for books would be greatly reduced, and we would not try to read much that is not of value to us.

Now I believe that every medical student should contribute his share to the general knowledge. If you have discovered some new sign symptom, germ or treatment, send it to the head of the department, let him pass judgment, verify or disprove, and if found valuable let it be placed in its appropriate place of things a physician ought to know. In that way we would all be aiding, and if our thoughts were good, they could be handed down to posterity.

I hope I may not offend anyone by this statement, but I think we would be much benefitted in our meeting if we presented papers, not on the treatment of diseases, but on things that can not be found in text books on treatment. I like to hear papers on just such subjects, as the treatment of pneumonia, yet when all has been written and said, how many of us would prefer the

learned paper to the best text book articles on the same subject?

Prof. Ludvig Hektoen expressed my idea when he says, "I will not lecture on things that may be found in text books, but will devote my time to things new, that you can not yet glean from the literature".

I ask you do you not believe that the attendance at our county, state and other societies, would be greatly increased if we all would present something new, that would be of value to the general practitioner.

What we need is to have every physician in Kansas belonging to all of our local societies, and not only belonging, but also contributing from his store of experience to the store-house of general knowledge.

Now I apprehend there will be some opposition to the proposition of each medical man spending six weeks in doing post-graduate work. It does seem hard to deprive a man of his income during that time, and it may be difficult for one to leave, yet in the long-run it will be better for the profession, and certainly much to the advantage of those who employ us

I suggest such a plan as this: Let neighboring physicians do our work while gone and keep account of it and then settle the difference in dollars, when the work at school is finished, in this way it would not work an inconvenience to him who took part in post-graduate work during the busy season.

So much for the education of the profession. The progress that will ensue from such work as outlined above will not be effective unless we can secure the co-operation of the laity. The people are becoming enlightened in other lines, and they must receive education at our hands, or they will be willing to be educated by the patent medicine trust, or else join some new drugless fad of healing.

We must convince them of the dangerous character of quarantinable disease, before we can expect them to be willing to obey quarantine laws. We must teach them the dangers of the social disease if we expect them to live chaste lives; we must inform them that they can not worship at the shrines of Bacchus and Venus if they do not intend to pay the penalty, and bring a degenerate race into the world.

How shall we educate the people? By public lectures those lessons that can be taught publicly. I believe a lecture once per month on some live medical subject by the family doctor would be of great help. The subjects could be outlined by some central like the "State Board of Health," so that a uniform instruction would be given in all places.

Shall the lectures be free? I think not. People have the idea that free things are not worth attending. No, I think it best to charge a stiff admission fee, and have it understood that the proceeds are to be for charity, for which each community has so much need.

The family doctor, I believe, can do more good in lecturing to his people than some strange person, for the people are as a rule willing to listen to him.

We are recognized as having the most altruistic profession in the world, we aim to so keep it. No other way can we keep our places in the hearts of the people than by educating them. Some one is doing it now, and it is not the family doctor.

Let the state of Kansas do it through its doctors, who are in sympathy with such education, and not the trust that wants impure food, mis-branded and adulterated drugs.

Light has come and no secret drug or impure food has a right to live, and I know the profession of Kansas is ready to wipe out the blot that has besmirched our fair state.

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THE OPEN TREATMENT OF FRACTURES.

DR. J. T. AXTELL, Newton, Kansas.

Read before the Golden Belt Medical Society, Enterprise, Kansas, May 11, 1912.

The treatment of fractures is one of the very oldest surgical procedures in the history of medicine.

The advent of a fairly satisfactory bone plate together with the X-ray work which has been done in the last few years requires a revision of our treatment of fractures.

The X-ray has shown us how very poor our work has been. We have all been surprised at the good functional results often obtained when the X-ray showed how poorly the work was done and how much better work could be done.

The advent of antiseptic surgery made a wonderful difference in the mortality of compound fractures.

Bone surgery is the great field for mal-practice suits and for this if for no other reason, we should be well prepared to do the best work possible. The people are demanding good results as shown by the X-ray.

A few years ago Mr. Lane invented a steel plate to be fastened to the ends of the broken bone by screws which has proved very satisfactory. It has been found that the plates must be of

the very best and strongest material or they will break. No metal is better than steel. The screws are threaded to the head and must fit the plate. They must be ½ inch or more from the end of the broken bone to avoid the splitting of the bone. Holes must be drilled in the bone and the drill should be the size of the core of the screw. The plate may be laid over the periosteum which it does not injure.

Two good assistants should manipulate the limb to get it in line, and the surgeon needs one clean assistant. The ends of the bones may be turned out, when then the ends are in apposition, put back. In compound fractures instead of scrubbing with soap and water, better results are obtained by using a fresh solution of iodine, one-third the strength of the tincture or 2½%. This may be used freely in the wound without water.

The most rigid asepsis is required. It is difficult to emphasize this point too much. It is much more important than in abdominal or brain surgery.

The fingers, even gloved, should never enter the wound. The handling of plates and screws must be done with instruments. Faulty technic is the common cause of failure. The screws will not stay in place if infected.

The X-ray should be used in all cases of suspected fracture when there is any doubt. It should also be used after setting each fracture. Retention splints like plaster casts, should not be neglected even after using the plates. An anaesthetic should be used in the reduction of any fracture.

Some enthusiastic advocates of Lane's plates have recommended them in all fractures. This is probably going to extremes. Fractures which can not be properly reduced or easily held in place should be treated by the open method. Cosemtic results weigh little against danger to life. Poor functional results often call for interference. The mortality in fractures even by conservative methods is much higher than is usually believed. In non-union and in some cases of delayed union, the open method of treatment is the best. It is still an open question whether an immediate operation should be performed or wait a few days until swelling has subsided a little and a certain amount of resistance is acquired. There are advantages and disadvantages both ways. Each case should be decided for itself.

SUMMARY.

A full line of instruments is essential.

The very strictest asepsis must be observed.

Plates should be used only in cases difficult to reduce or to keep reduced, in compound fractures, for non-union, and to correct a very bad result.

The operation may be at once or a few days, as seems best. Outside retention splints are not to be neglected.

Mortality is a factor not to be ignored.

An anaesthetic should be used in all fracture cases and the result proved by a skiagraph.

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THE USE OF CALCIUM CHLORIDE AS PROPHYLAXIS AGAINST HEMORRHAGE IN TYPHOID FEVER.

DR. N. E. WILSON, Douglas, Kansas.

Read before the Butler County Medical Society, June 20, 1912.

Intestinal hemorrhage occurs in typhoid fever in from three to ten per cent of all cases, varying with the reports of different epidemics and different reports of various authors. Osler sums it up by saying, "that seven per cent of all typhoids have intestinal hemorrhage." The hemorrhage of course is due to the ulceration occuring in Bruners glands and Pyers patches. The blood vessels supplying these structures are small and I believe the loss of blood is entirely out of proportion so far as the amount of blood lost is concerned to the pathological lesion. The majority of patients suffering from hemorrhages recover, nevertheless Tyson reports eleven deaths caused by hemorrhage out of a mortality of fifty-six occuring in a record kept on six hundred and eighty-five cases. This would indicate that twenty per cent of all deaths in typhoid is due to hemorrhage. This, I believe, to be more than the average death rate, never the less, I believe it bears out my statement that the loss of blood is out of proportion to the pathological lesion. This discrepancy I believe, to be due to the changes which occur in the blood during typhoid fever retarding clot formation. We have all noticed the fact that epistaxis which occurs early in the disease is generally easily controlled, generally stopping spontaneously; in other words the blood clots about normally and any difference from the normal at this time could probably be accounted for by the increased blood pressure due to increased temperature and the prone position, but you have also seen epistaxis occur the second or third week of the disease which required packing of the nostril and sometimes the hemorrhage was alarming and even fatal. This difference I believe to be due to the same cause as the profuseness of the intestinal hemorrhage

namely the blood changes caused by the disease are such that clot formation is retarded or in some fatal cases prevented. Let us consider for a moment the physiology of clot formation. Blood clot consists of fibrin collecting in its meshes red and white blood corpuscles. Fibrin does not exist in the blood normally as such, but must be formed after the blood is liberated. Sterling says fibrin is formed by the action of fibrin ferment on fibrinogen in the presence of calcium chloride. These three being normal constituants of the blood when liberated unite to form fibrin and the fibrin collecting in its meshes the corpuscles form blood clot. Tysen, Osler, Holt and others, agree that the red corpuscles are markedly reduced in typhoid fever; the change beginning about the second week of the disease and continuing until convalescence. Unlike most infectious diseases the white corpuscles are also reduced in number. I have seen no literature on the subject, but I believe the chlorides are likewise reduced, consequently, fibrin formation is slow. Fibrin formation being slow with a more fluid condition of the blood caused by reduction of the number per volume of the corpuscles retards clot formation. Now, theoretically, if you increase the calcium chlorides in the blood you facilitate clot formation. Concerning the physiological action of calcium chloride, Potter says, "calcium chloride possesses a high coagulating power on the blood; its deficiency gives rise to lymphatic and osseous disease, and absence resulting in emaciation and death. It is excreted almost entirely by the intestines, a small portion being absorbed and but little passes out by the kidneys." Barthlow, "calcium chloride is very diffusible entering the blood in small quantities promotes constructive metamorphosis." Now, if it possess a high coagulating power on the blood and is excreted almost entirely by the intestines that gives an excess of it just where it is most needed in case of intestinal hemorrhage. The consideration of these facts caused me four years ago, to begin the use of calcium chloride in typhoid fever. Beginning with the diagnosis of the disease I give to an adult five grains of the drug well diluted every four hours. This is continued quite regularly through the first two weeks of the disease and if the case holds on may be repeated for a few days the fourth week. At the end of two weeks I figure that the excess of calcium chloride in the blood will facilitate clot formation during the time hemorrhage is most likely to occur, if however, the disease lasts into the fourth week, I repeat it for the first few days. The drug carried too far causes a retrograde metamorphosis, hence the peroid of rest the third week. Since I began using calcium chloride I have had thirty

cases of typhoid which have received this treatment. All have been typical cases and though the Widal test has not often been used to prove the diagnosis the clinical symptoms are such as to render the Widal unnecessary; insidious onset, loss of appetite, evening rise and morning remission of temperature, tympanites and abdominal rose spots. Of the thirty cases twenty-seven of them had no hemorrhage and the other three showed just a trace of blood in one stool each. In no case did the loss of blood amonut to one ounce. I have seen no ill effects from the use of calcium chloride. It does not even disturb the stomach, and I believe the three cases in which there was a show of blood in one stool, might have had severe hemorrhages had it not been for the previous use of calcium chloride. I realize that my list of cases is not sufficient to conclusively prove my theory, but considering the fact that the drug in no way interferes with the patients welfare and recovery, I feel justified in presenting it to you for your consideration.

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TREATMENT OF TYPHOID FEVER.

DR. W. C. CHANEY, Independence, Kansas.

Read before the Southeast Kansas Medical Society, Fort Scott, April 9, 1912.

In presenting the subject of the treatment of typhoid fever, I shall not take up your time with a discussion of the etiology and pathology of the disease, except as may be necessary in making plain certain points of the treatment.

The severity of the general typhoid symptoms is dependent to a very large degree upon the severity of the bowel manifestations. The high fever, nervousness, delirium, and all the other toxic symptoms are, in almost every case, due to the absorption of toxines formed in, and retained by the bowel. In any fever the tendency is toward a putrifactive fermentation of the digesting food in the intestine, and in typhoid fever this tendency is made much more certain by the action of the typhoid bacilli upon the mixture of digesting food, catarrhal mucous, and the pus from the ulcerating Peyer's glands. The final product being the formation of a very severe form of toxines in the bowel, the absorption of which produces the severe toxic symptoms so usually seen in typhoid fever.

In discussing the treatment of typhoid fever it would appear, therefore, that any measures which will prevent this putrifactive fermentation taking place in the bowel will prevent, to a very large degree, the toxic symptoms of the disease.

The treatment of typhoid fever consists in, rest, diet, elimination, antisepsis, hygiene, prophylaxis, and immunization.

The general management of all cases of typhoid fever consists in putting the patient to bed in a well screened, well ventilated room, shut away from the rest of the house as much as possible. The patient to be kept absolutely in bed from the beginning of the treatment until convalescence is well established, under no circumstances being allowed out of bed until at least seven days after the fever has entirely disappeared.

Such persons only as are needed for the care of the patient should be permitted in the room, and whenever possible the case should be in charge of a trained nurse.

The diet should consist of such foods as are easily digestable and which leaves behind the smallest amount of residue to form feces. The tastes of the patient should be considered to some extent in the selection of the diet. Adult patients should be fed at regular intervals and not oftener than every three to four hours. The feeding should be continued through the night; except in cases that do not drop back to sleep readily after taking nourishment, when the night feeding should be discontinued. For the first few days of the treatment the diet should be restricted just as much as possible. This allows time for thoroughly emptying the bowel and for relieving the general system of much of its load of toxines. After this period of restricted diet every case of typhoid fever should receive just as much food as that individual case can digest and assimilate.

The diet should be varied as much as possible and should consist of diluted sweet milk, butter milk, whey, raw eggs, custards, clear consome, meat juices, meat broths, strained cereal gruels, orange juice, lemonade, pine apple juice, unfermented grape juice, cocoa, etc., etc. The broths may be seasoned with vegetables or celery salt. From this list the patient's tastes may be fairly well satisfied, and the patient can be kept quite well nourished for a considerable length of time.

The stools should be watched carefully for evidences of undigested food; and should particles of undigested or unassimilated food begin to appear in the stools the food should be decreased in amount, and this failing to relieve the condition such foods as are not being properly cared for must be eliminated from the diet.

Water taken into the system reduces the fever and flushes the kidneys and bowel. The drinking of water that has been boiled and then cooled should be encouraged. An adult patient should drink four to five pints during the twenty-four hours.

Spirits are not necessary and should not be given, except in cases of extreme weakness.

The successful treatment of typhoid fever depends quite as much on the care with which the eliminative treatment is carried out as it does upon proper dieting. Elimination is effected chiefly through the bowel, kidneys and skin.

As regards the use of hydrotheropy I will have little to say. The very beneficial results obtained from the use of baths in typhoid fever is too well understood to need further discussion. Suffice to say that it makes no difference which form of bath is used so long as the desired results are obtained. The temperature is to ke bept at 102 or lower, and whenever the temperature goes above 102 the bath is to be used. In private practice fewer objections are met in giving the sponge bath, and if properly given is quite as effective as either of the other methods. The patient's hands and face should be bathed frequently with tepid water, and once a day a warm sponge bath should be given the entire body.

Further eliminative treatment is to be induced by the administration of drugs. Here let me digress just a little: Osler in his practice of medicine says, "In hospital practice medicines are not often used and are not needed. A great majority of cases do not receive a dose." Also note this statement from another writer: "The satisfactory results obtained in the treatment of typhoid fever are due to good nursing, diet, hygiene, and hydrotherapy; and not to any system of drug administration."

And again from Osler, "In private practice it may be safer, for the young practitioner especially, to order a mild fever mixture." These men tell us that the death rate from typhoid fever is from 7 to 20 per cent in hospital practice, while in private practice it is from 5 to 12 per cent. Thompson says "Enthusiasts of drug administration should concider that fully 80 per cent of all cases of typhoid fever terminate in recovery, no matter what line of treatment is carried out." And again, Osler says, "Constipation is present in many cases, and though I have never seen it do harm, yet it is well every third or fourth day to give an ordinary enema.

Surely such statements as the above can not be accepted as authority for the proper treatment of typhoid fever at this time. Are we to content ourselves by bathing the patient, giving a liquid diet, and keeping the surroundings clean; while such a large per cent of typhoid patients die from toxemia, the result of improper or rather of no elimination? A death rate of even 5 per cent in typhoid fever shows gross negligence on the part of the physi-

cian in charge. Not one here would allow a boil or an abscess to go unopened, depending upon the general system to absorb and throw off the poisons generated in the infected area. Neither should the cast off products from the ulcerating Peyer's glands be allowed to remain in the bowel, to become mixed with the digesting food, the whole mixture going through a putrifactive fermentation with the production of toxines; yet this is exactly what is allowed when no eliminative treatment, other than the the baths, is given.

If seen early in the beginning of the disease a stiff hepatic purge, followed by a saline laxative, should be given. Following this initial purge the patient should be given every morning (except in case of hemorrhage), either a saline laxative or a dose of castor oil. My preference is for the castor oil in dosage enough to produce one or two bowel movements. Four to six bowel actions during the twenty-four hours, while not desirable, will do no harm.

The argument that the giving of cathartics tend toward starting up a diarrheal trouble that may later prove troublesome has not been borne out in cases treated by me. Much better results are obtained in the treatment of typhoid fever by keeping the bowel acting every day, than by giving no cathartics, allowing the bowel to go for three to four days without a movement and then merely move out the lower bowel by an injection of water. There can be no excuse for letting the typhoid patient retain the intestinal contents for days to undergo putrifactive fermentative changes. For as stated before, it is the absorption of the toxines produced by these changes that not only produce all the severe toxic symptoms of typhoid fever, but which is directly responsible for most of the deaths from this disease.

The kidneys must be kept active, and for this purpose water in generous amounts is no doubt the best treatment. Frequently it may be necessary to give a diuretic and for this purpose potassium acetate and urotropin given in doses of five grains each, well diluted every six hours have proven very satisfactory.

Hand in hand with the eliminative treatment should go the intestinal antiseptic treatment. Much has been said both pro and con concerning the merits of intestinal antisepsis. I am not in a position to say whether the intestinal canal can or can not be disinfected. Of one thing, I am very certain, in typhoid fever it is possible to give drugs that will entirely destroy the odor of the typhoid stool, and that will prevent the tympanites. The intestinal antiseptic treatment combined with the eliminiative treat-

ment, by preventing putrifactive fermentation taking place in the bowel, prevents the formation of toxines. Thus, with no toxines to be absorbed the toxic symptoms of the disease are absent. It has been my experience that, in every case of typhoid fever, just as soon as these two conditions were realized, that is just as soon as the stools became deodorized and the tympanites relieved, all the other symptoms were reduced to the minimum, the patient being fairly comfortable, and the case presenting as one of very mild typhoid fever.

Let me quote from Thompson's Practical Dietetics. In discussing the relation of intestinal antisepsis to diet in typhoid fever he says, "While there are as yet no remedies known to therapeutics which can be used in sufficient strength in the intestine to be completely antiseptic or germicidal to the typhoid bacilli, there is another aspect of antisepsis, or rather asepsis, of the intestinal canal, which should not be overlooked—that is the prevention of those putrifactive fermentative changes which accompany indigestion in any fever. Moreover, it would appear that the over distention of the intestine by flatus must have a very injurious effect upon the ulcerating surfaces by stretching them. At autopsies upon typhoid patients, ulcers are often seen which might have been easily torn by slight distension, and the prognosis of typhoid fever is more grave when extreme and obstinate intestinal flatulency appears early in the disease, before there has been time for either perforation or peritonitis. One can do much to prevent this condition by bestowing special care upon the whole alimentary canal."

In producing this antiseptic or aseptic, condition of the intestinal canal it has been my custom for a number of years to give every case of typhoid fever Abbott's intestinal antiseptic tablets. Each tablet of which contains zinc sulphocarbolate ½ grain, lime sulphocarbolate 1 grain, sodium sulphocarbolate 3½ grains, bismuth salicylate ¼ grain, and menthol, 1-15 grain. Two of these tablets are crushed and dissolved in hot water and given every three hours until the odor disappears from the stool and the tympanites is relieved; then in dosage sufficient to maintain these conditions.

These tablets are not poisonous and may be continued in large doses indefinitely. They should be continued until the patient is well along the road to convalescence. Whether these tablets are disinfectants to the intestinal canal or not, I cannot say. That they prevent putrifactive fermentation taking place in the bowel, that they deodorize the typhoid stool, that they indirectly aid digestion, that the toxic symptoms of typhoid fever are reduced

to the minimum, that the patient is kept fairly comfortable, that the fever is kept relatively low, and finally that the course of the fever is shortened from four to ten days by thoroughly saturating the patient with these tablets are facts proven again and again in treating typhoid cases.

If seen after the fever is well established, I frequently add to the above treatment the acetezone water, letting it take the place of the plain water. Fifteen grains of acetezone are dissolved in boiling water, strained through a heavy cloth, and water added to make one gallon. The patient is encouraged to drink four to five pints of this a day. This acts very nicely as an aid to the antiseptic treatment in producing the desired condition in the alimentary canal.

The giving of antipyretic drugs for the control of the temperature is absolutely to be condemned. In no case should they be given.

The care of the mouth is very important. No one thing in typhoid fever adds more to the comfort or discomfort of the patient than does the condition of the mouth. The mouth should be washed frequently and at regular intervals, and should always be rinsed after feeding. Listerine, glyco-thymoline, dioxygen, or a weak salt water make very satisfactory and cleansing mouth washes. The tongue may be scraped with a dull scraper and the gums, teeth, and buccal cavities washed with cotton or a soft cloth. Frequently patients are allowed to chew gum for short intervals at a time. This greatly stimulates the salivary glands, and relieves the dry condition of the mouth.

Such hygienic and prophylactic measures must be carried out as will guard against a spread of the infection. It is quite as much the duty of the physician to see to the effective carrying out of all such measures as is the care of the patient. He should remember that every member of the household has most likely been exposed to the same source of infection. He should discover if possible the source of infection and take such steps as will destroy it, and he should guard against the development of cases in other members of the household.

After each stool the patient's perineum and adjacent parts should be washed and then sponged with a 1-2000 bi-chloride solution.

The excreta must be thoroughly disinfected before being disposed of. The bed-pan should be kept about one third full of the disinfecting solution used and ready for use. Any lumps of feces should be broken up so that the disinfecting solution may per-

meate the entire mass, with which it should be left in contact for two hours. As a final disposition the excreta should be placed in a pit, fixed with saw dust or other suitable material, saturated with oil and burned. The pit should then be covered with a layer of lime and then a layer of dry earth.

The disinfecting of the excreta should begin as soon as a diagnosis of typhoid fever is made and should be continued until the bacilli entirely disappear from the feces and urine.

The patient's linen and bed linen should be changed daily and at such other times as they may become soiled. All linen and bed-linen used about the patient should be soaked in a 1-20 phenol solution, washed and thoroughly boiled; and should be done separately from all other wash.

Everything used about the patient should be kept separate from the rest of the household furnishings, and all utensils and dishes should be immediately disinfected after being used.

Nurses and attendants should immerse their hands in a 1-1000 bi-chloride solution each time after waiting on the patient.

As regards immunization the time is here when every person suspected of having been exposed to the infection of the typhoid bacilli should be given the typhoid vaccine treatment. This consists in giving three subcutaneous injections of the killed typhoid bacilli at ten day intervals. The first injection contains 500 million killed bacilli and the other two 1000 million each.

The treatment of the complications of typhoid fever is not to form a part of this paper. I wish to say, however, that if the treatment of the typhoid fever itself is carried out as outlined above, the complications will be very few.

Just a word in regard to when convalescent typhoid patients should begin to have solid food. As stated above, the patient is to be kept in bed for seven days after the fever has entirely disappeared. They may begin to have an extra pillow the fourth day after the fever has disappeared, and each succeeding day may be raised a little more, so that by the end of the seven days they are ready to sit up for a few minutes. The regular typhoid diet should be cautiously increased in amount as the fever disappears and at the end of the week after the disappearance of the fever solid food may be given. A very little should be given at the start but the amount should be gradually increased each day as the patient is able to handle it.

In closing let me repeat that the general management of all cases of typhoid fever consists in absolute rest in bed, special typhoid diet, elimination through all the emunctories and especial-

ly through the bowel, intestinal antisepsis as a means of preventing putrifactive fermentation taking place in the bowel, strict hygienic and prophylactic measures to prevent a spread of the infection, and the employment of the typhoid vaccine with every person suspected of having been exposed to the infection of the typhoid bacilli.

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The history of a fairly sudden enlargement of a testicle does not necessarily mean an inflammatory or traumatic process. Such an enlargement may be due to spontaneous hemorrhage in a round-cell sarcoma of the organ.

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Translucency in a scrotal swelling indicates, of course, the presence of hydrocele fluid. But if the shadow of the testicle within is unduly large the hydrocele is only a complication of some other condition, e. g., neoplasm of the testis.

A testicular enlargement, even though of rapid development, not associated with evident urethritis, not very tender and not following instrumentation, should never be dismissed as due to "a strain." It is in all probability neoplastic, luetic or tuberculous. If the Wasserman reaction is negative, the testicle should be promptly examined by operation!

A biliary fistula with patent cystic and common ducts may be used as a means of introducing medicaments or fluids into the bile tract or upper bowel.

Paronychiae may often be thoroughly drained by gently passing the knife point between the nail fold and the lunula without cutting the true skin. Disinfect with a drop of tincture of iodine, insert a tiny gauze drain and apply a small wet dressing.

If suppuration at the root of the nail does not soon subside after providing drainage, it may be necessary to remove the nail. This should not be done too hastily, however. Persistence in daily disinfection of the space (iodine, hydrogen peroxide, etc.) and stimulation of the tissues (as by massage) will often be rewarded by saving the nail.—Surgical Suggestions from American Journal Surgery.

THE JOURNAL OF THE Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, J. E. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

Subscription Rates: $2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft, Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr, H. G Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian. S. G. Stewart, Topeka.

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EDITORIAL

To the Secretaries of the County Medical Societies.—Please send all medical news of your county, viz., marriages, births,deaths, removals and medical meetings, to your councillor or the Journal for publication.

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Every physician who has the interests of his profession and patients at heart, should make a special effort on (and before) election day, to put in office men who will be favorable to the passage of laws conserving the life of humanity. Of course, the candidate to be supported should be questioned before-hand and his attitude in respect to good medical legislation made positively known. We wonder how many physicians have taken it upon themselves to get this information. The most of us usually wait until after election to find out how legislators stand on questions of vital interest to the profession and such time is nearly always no time at all. We should by all means get the prospective legislator 's opinion on health laws before election day, and if they are detrimental, support the other fellow whose efforts will be directed along honest and consistent lines. If we had been awake some time ago in this respect, perhaps the Owen Bill would have had smoother sailing. We must be up and doing.

B. H. Rhoads a "chiropractor" of Sterling has recently been twice arrested for practicing without a license. The first case was appealed to the District Court by the defendant, and comes up in the September term. The second arrest was on eight counts. The "Doctor" asked for a jury trial. The night before the time set for trial Dr. Palmer, president of the "Chiro" school of Davenport, Iowa, gave a free lecture on "Chiropractice" at the opera house. It had the desired effect. The next day with the aid of three lawyers and Dr. Palmer as an expert witness, the jury decided that he was not guilty. Although the Supreme Court has given its decision in two similar cases and said that they were guilty. So you see, Chicago isn't the only place 'Steam Rollers' are in use.

W. E. CURRIE.

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Since the fall meetings of county and district societies will soon commence it might be well to emphasize the benefit gained by attendance. To our mind, this is embodied in an editorial we published some months ago, and which is as follows:

What a Medical Society Means to a Physician.—It means, first, a constant post-graduate course of study. Where physicians, both old and young, meet on an equality, discuss cases from every angle, advance new ideas and review the older ones. Where theory and practice are put to the test and worked out to successful conclusions. Where cases of doubtful diagnosis can be discussed and experiences related along lines of mutuality. Where almost forgotten teachings are brought to mind, and their importance realized. Where a flagging ambition is stimulated and new courage instilled. Where friends and good-fellowship are renewed and relaxation enjoyed. Withal it means keeping abreast of the profession and not in the rear rank. Can you afford to do without it?

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EDITORIAL CLIPPINGS.

What is an Enzyme?—There are few persons who have the facility of expressing a somewhat abstract scientific conception in terms of an analogy that strikes home at once. Emil Fischer furnished an admirable illustration of what we have in mind when he elucidated, by a now famous phrase, the specificity of enzymes, that is, the capacity of digestive ferments to attack one substance and not another which may even be closely related. Enzyme and substrate, according to Fischer, bear a relation to one another

like that of a key to its lock. Not all keys will open all locks. The configuration of the two factors must be appropriate. Decidedly forceful and unquestionably unique is the description of the distinctive peculiarity of enzymes lately published by the London physiologist, Professor Halliburton, in a primer intended for the general reader. "We may roughly compare an enzyme," he writes, "to an ill-disposed person who comes into a room full of good-natured people, and who succeeds in setting them all by the ears. He has produced a change in them without undergoing any change himself, by his mere presence. He is, moreover, able to repeat the process over and over again in fresh roomfuls ad infinitum." Perhaps the expression "enzyme" will now acquire a wider usefulness as a descriptive term for a not entirely unknown type of human being.—Journal A. M. A.

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The Metric System.—It is strange that an intelligent body of men like the medical profession would advocate the use of the metric system, when our present system of weights and measures is so ample and so familiar.

It would take almost a century for the public to familiarize itself with the metric system. In France, where it was originated, the system has never been assimilated by the general public and the former weights and measures are employed. The educated class of course understand the system, but the masses have thoroughly assimilated the old order and can not be brought to adopt the new for many years to come.

The metric system as a means of weights and measures in prescriptions is open to many objections. In the first place, it is more complicated than the present method. In the second, the amount specified requires more words of characters than apothecaries weight. This is a serious objection.

Again, in order to order a dose of a drug like atropine or hyoscine an array of decimals is necessary, and these produce bulk and frequently confusion when this is unnecessary under the present order.

Certainly we ought not to invite confusion and possible errors. These creep into our work frequently enough any way, but why should we invite by a strange foreign system that is complicated and has nothing to recommend above apothecaries that we all have assimilated.

We earnestly hope that the metric system which has threatened for a generation to foist itself upon us will not gain a footing in the United States. In Great Britain it is true that many phy-

sicians, use it as many do in this country, but the general tendency there, as it is here, is to look upon the metric system as complicated and not suited for general purposes, and that there is no excuse for substituting it for one that is familiar and by no means complex.—The Therapeutic Record.

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The Menace of Wood Alcohol.—The wide-spread discussion which followed the series of deaths in Berlin as a consequence of the drinking of liquors contaminated with wood alcohol has again attracted attention to its poisonous character. There has been considerable difference of opinion as to whether the poisonous effect of this substance is actually due to the alcohol itself, or to some impurities, which are almost invariably present in all except the most refined products. There is a scarcity of facts regarding the actual behavior of wood alcohol in the animal body, so that the underlying causes of its extremely poisonous character are by no means clearly understood.

With respect to ordinary grain alcohol, the component of our alcoholic beverages, the facts are better understood. Ordinary alcohol is, when taken in moderate quantities, rapidly burned up in the body. This fact has been demonstrated by numerous experiments. With wood alcohol, however, the case seems to be different, according to the recent investigations in the Institute for the Fermentation Industries at Berlin. It has been shown that when wood alcohol is administered to animals it may not be eliminated completely, even at the end of two days. The repeated ingestion of considerable doses of wood alcohol may lead to a dangerous accumulation thereof in the body. This factor has heretofore not been duly appreciated. These subtle dangers associated with the use of wood alcohol deserve wide-spread notice because of the increasing danger of its unsuspected entrance as an adulterant of the cheaper grades of distilled liquors and certain medicinal products. The insatiable demand for cheap liquors among certain of the degraded classes, says the Journal of the American Medical Association, and the difficulty with which the admixture of the inexpensive wood alcohol is detected provide a constant temptation to the unscrupulous dealer and a menace to the health of certain classes. However, objectionable adulteration may be on general principles, it becomes far worse when some subtle danger is harbored therein.

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Hot-Air Treatment for Diphtheria.—Recent investigations by Rendu indicate that inhalation of hot air may become a valua-

ble ally in the treatment of diphtheria. The bacillus of diphtheria is more susceptible to heat than are most pathogenic organisms. According to Rendu's results exposure to a temperature of 176 F. (80 C.) for one minute, of 140 F. (60 C.) for ten minutes, or of 122 F. (50 C.) for fifteen minutes is sufficient to kill the diphtheria organisms. This, together with the fact that the bacilli grow in rather an exposed location on the surface of the membranes of the mouth and pharynx, led to the experiments in the use of heated air. Rendu found by experiments on himself that a temperature of 212 F. (100 C.) for a period of two minutes could be supported without imconvenience, and that a temperature of 140 F. could easily be endured for more than half an hour. Following this experiment diphtheria patients were exposed to a temperature of 176 F. for five minutes with satisfactory results, and Rendu became convinced that this measure markedly inhibits the growth of the bacteria and shortens the course of the disease. He does not suggest the hot-air treatment as a substitute for antitoxin, but as a supplementary measure. His suggestion seems rational, for if both heat and antitoxin inhibit the development of diphtheria bacilli a judicious combination of the two may be expected to accomplish more than either one singly.
—Journal A. M. A.

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SOCIETY NOTES.

1st District, C. W. Reynolds, councillor, Holton—No report.

2nd District, C. C. Goddard, councillor, Leavenworth—No report.

3rd District, H. B. Caffey, councillor, Pittsburg:

The Labette County Society met in Altamont, July 24th, with 17 doctors in attendance.

Several interesting clinical cases were present, one by Dr. S. J. Dobson, of Edna, brought out much discussion. The patient, a child of 2½ years with what appeared to be tubercular peritonitis. Considerable doubt as to operative benefit, was expressed.

The general topic of the evening was obstetrics and gynecology.

Dr. E. W. Boardman discussed normal labor and pregnancy; Dr. R. M. Bennett discussed abortions; Dr. M. L. Perry talked on the 'Psychoses of Reproduction.';Dr. Moerow read a paper on 'Eclampsia and the Toxemias of Pregnancy.'

O. S. HUBBARD, Sec'y.

4th District, W. E. McVey, councillor, Topeka—No report.

5th District, W. E. Currie, councillor, Sterling:

The regular monthly meeting of the Reno County Medical Society was held at Hutchinson, June 28th, with a full attendance. Dr. W. Monroe Jones read a paper on "Chronic Dacryocystitis. Dr. H. L. Scales led the discussion.

The society is in better condition and has more members in good standing than it has since it was organized in 1904.

The society has adjourned for the summer.

W. F. SCHOOR, Sec'y.

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Following is the program of the Harvey County Medical Society for August:

"Exophthalmic Goiter," Dr. A. E. Hertzler. Discussion—Dr. J. L. Grove.

"Adenoids," Dr. O. W. Roff. Discussion—Dr. A. E. Smolt.

"Diphtheria," Dr. R. H. Hertzler. Discussion—Dr. E. E. Wuttke.

F. L. ABBEY, Sec'y.

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On June 6th, Barton, Rice, Reno, MePherson and Stafford County Medical Societies met in joint session at Great Bend. A number of very interesting clinics were given, and a good program. Dr. Frank Hall of Kansas City, gave an illustrated lecture on Syphilis. A telegram was sent to Senator Bristow and Curtis, asking them to support the Owen Bill.

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Peabody, Kans, July 17, 1912

The Marion county medical society met in regular session at Peabody with Drs. S. Johnson and Mayer as hosts.

An excellent paper on 'Summer Diarrohea of Infants', was read by Dr. C. P. Brunig of Lehigh; the subject being ably discussed by all doctors present, including Dr. John Scott, of Kansas City, Mo.

Dr. Grant Meyer of Lincolnville, was unable to be present, necessitating deferring discussion of paper he was to have presented.

Only ten members were present but it was an interesting session.

Adjourned to meet pursuant to program at Hillsboro, in September with Dr. Reigle as host.

H. BRUNIG, President. C. L. APPLEBY, Sec'y.

6th District, Arch D. Jones, councillor, Wichita—No report.
7th District, W. F. Sawhill, councillor, Concordia—No report.
8th District, O. D. Walker, councillor, Salina—No report.
9th District, C. S. Kenney, councillor, Norton—No report.
10th District, E. J. Beckner, councillor, Seldon—No report.
11th District, J. A. Dillon, councillor, Larned—No report.
12th District, W. F. Fee, councillor, Meade—No report.

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HOT SPRINGS IN OCTOBER.

The above refers to the next annual meeting of the Medical association of the Southwest, which will be held October, 8-10. The headquarters will be at the Arlington Hotel.

Many strong men have already promised contributions to the program which bids fair to be the best yet held. Each year these meetings have increased in strength of program and attendance and the officers expect that this will be no exception to the rule. The well-known hospitality of the fraternity of Hot Springs is all that is needed to assure a thoroughly enjoyable social time.

If you wish to present a paper write the Secretary at El Reno, Oklahoma, at once, giving the title of the same.

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The fourth annual meeting of the American Association of Clinical Research will be held in New York City, at the Academy of Medicine, on November 9, 1912.

The sessions will be held from 9 a. m. to 1 p. m., from 3 p. m. to 6 p. m. and from 8 p. m. to 10 p. m. The evening session will be open to the public.

Notable contributions on the Negri Bodies, on certain Fluids for Tubercle Bacilli in the Urine, on Adjustment and Function, on Psychoanalysis and Traumbedeutung, on a Pandemic of Malignant Encapsulated Throat Coccus, on The Single Remedy on Indicanuria and Glycosuria, on Disease Conditions expressive of Correct Diagnosis, on Biochemic Problems, on The two Most Far-Reaching Discoveries in Medicine, and others are to be given. Every member of the Association is cordially invited to contribute a paper. The title should be sent at once to the Permanent Secretary, so that the program may be completed.

As soon as completed, the program will be mailed to you. Please make an effort not only to contribute a paper, but to be present at the coming meeting, to bring your friends, and to assist in the most important movement of medicine as represented in

the aim of our Association, the systematic, scientific investigation and advancement of medicine by conclusive clinical and clinically-allied methods.

Please invite your friends to become members. Your support and that of your friends will be cordially appreciated.

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NEWS NOTES

The American Academy of Ophthalmology and Oto-Laryngology will meet at Niagara Falls, August 20-22.

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The third annual session of the Clinical Congress of Surgeons of North America will be held in New York City, November 11-16. Franklin H. Martin, 31 North State Street, Chicago, is secretary.

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The twenty-fifth annual meeting of the Medical Society of the Missouri Valley, will be held at Council Bluffs, Iowa, September 5-6, under the presidency of Dr. J. M. Bell, of St. Joseph, Mo. A number of the presidents of the state societies in the district will make addresses.

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Dr. F. W. Shelton of Independence announces that Dr. J. S. Alford in now associated with him in hospital and private practice.

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Dr. M. L. Belot of Clyde, Kansas, was married July 12th, to Miss Anne Elvin of Marquette, Kansas.

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Dr. L. F. Barney of Kansas City, Kansas, is spending his vacation in Minnesota. He will spend two weeks at the Mayo hospital at Rochester.

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Dr. J. F. Hassig, secretary of the Wyandotte County Medical Society spent July in California.

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Dr. Hugh Wilkinson spent some of the "heated weeks" on the White river in the Ozarks.

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Dr. M. T. Sudler is spending three months in the East attending clinics.

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Dr. Joseph W. Howland of Topeka, was married June 30th, to Miss Annie Elizabeth Saunders of Sedalia, Mo.

Dr. Frances A. Harper of Pittsburgh, Kansas, is spending the summer at Green Brae Farm, Berlin, Mass. She has almost completed her book on "The Conservative Treatment of Diseases of Women," and it will be in the hands of the publisher shortly.

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Dr. and Mrs. H. G. Welsh of Hutchinson, attended the National Republican convention at Chicago.

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Dr. C. A. Mann of Hutchinson is doing post-graduate work in St. Louis.

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Dr. Frank D. Stinson was married to Miss Byrd Hartenbower, June 19. Both of Douglass, Kansas.

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NEWS OF THE THIRD DISTRICT.

Many of the physicians of Pittsburg are interested in the Crawford county automobile and good Roads association recently organized and will liberally support any measure that will improve the public highways and afford better protection to the drivers of motor cars.

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Dr. A. C. Graves, the mayor of Pittsburg, has been quite active in drawing up an ordinance relative to the numbering and driving of automobiles in the city limits.

Such an ordinance has long been needed and we are pleased that one of our doctors should be placed in the position to promote such an important matter of public benefit.

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Dr. C. A. Smith recently returned from a short visit to Chicago.

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The President of the Crawford County Medical Society, Dr. Gibb, has called a meeting of the doctors for Tuesday evening, August 6th, to appoint committees for the entertainment of the Third District Medical Society which meets in Pittsburg, September 25th.

The next issue of the Journal will contain full program.

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Dr. T. D. Blasdell has been appointed oculist for the M. K. & T., railroad in Parsons, to fill the vacancy caused by the death of Dr. George W. Maser.

Dr. Wm. C. Lathrop has moved to Salina and opened an office in the Estrand Block where he will devote his time to surgery exclusively. Dr. Lathrop has been at Norton for seven years and has devoted the last three years to exclusive surgery at the Norton Cottage Hospital.

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OBITUARY.

Ira W. Clark, M. D. Eclectic Medical College, Cincinnati, 1880; died at his home in Winfield, Kan., July 10, from typhoid fever, aged 55.

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MISCELLANEOUS

New York Christian Scientist Convicted.—Recent press reports say that Willis Vernon Cole, the Eddyist practitioner, whose first trial resulted in a disagreement, was convicted on the second trial on March 30, of practicing medicine without a license. In making the charge, Justice Seabury said that one who held himself out by sign, card or public advertisement as being able to cure, treat, or prescribe for any human disease, pain or deformity, or ailment and who maintained a public office to which persons might come for treatment and who receives a fee, is engaged in the practice of medicine under the meaning of the law. He said further, that, even though surgery was not resorted to and no drugs given, and even though the person so holding himself out engages in prayer, he is engaged in the practice of medicine under the meaning of the law. Cole was fined $100. The case was appealed.—Medical Fortnightly.

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Medical Reciprocity in Pennsylvania.—The Pennsylvania State Bureau of Medical Education and Licensure, created by the Legislature last year, has sent to every State in the Union the agreement to reciprocity on medical practitioners licenses' which it offers to other States. Reciprocity is to apply only to holders of diplomas from medical schools recognized as in good standing by the licensing authorities of the State in which the candidate seeks the right to practice. The bureau advocates a decrease in the number of medical schools, and an absolute standardization of entrance requirements.—Medical Fortnightly.

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A Lively Corpse.—A country doctor, returning from a visit

in the small hours of the morning, in the time of the "body snatchers," had to pass a secluded burial ground, in which a deceased patient had been interred the day before. When he reached the wall he saw a horse and trap standing unattended on the road outside. Looking cautiously over the wall, he saw that two men had just disinterred the corpse. Standing in the shadow of the wall, he saw them bring out the body and place it in a sitting position on the seat of the trap, so that, when they drove away, the body, which they had wrapped in a dark cloak, would in the dimlight look like a third man, sitting between the other two. They then got over the wall again to fill in the grave. The doctor lifted the body down from the trap, laid it under the wall and seated himself in its place. After a short time the two men got over the wall again, threw their spades into the back of the trap, seated themselves one on each side of him, and drove off. Presently one of the men said to the other: "The body seems to be warm still." The other replied: "So it is." Then the corpse said, "Warm! and if you had been where I have been for the past twenty-four hours you would be warm too!" The two men leapt with a yell out of the trap at opposite sides and ran for their lives.—British Medical Journal.

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For Sale.—1 X-ray coil, Scheidel; 1 rheostat, (wall-plate); 1 high frequency apparatus; 1 tube stand.—Mrs. John Troutman, 902 N. 7th St., Kansas City, Kansas.

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Breathes there a Doc with soul so dead, who never to himself hath said: "Dadburn it all! From this time on, I'll make no calls without the Spon? My ancient hoss I'll give a rest, unless I am with fees more blest This thing of getting up at night, and riding miles to some poor Blight, without a cent to buy the feed consumed alone by my old steed, gives me a Pain.

"For years I've pandered to the whims, of half thousand or more Slim Jims; Neglected my wife and missed by the kids, getting my fees in only small dribs. From now on my work will be wholly cash, and I'm through with the helping of poor white Trash."

But at 2 a. m. the door-bell sounds, and you're out on your feet in a couple of bounds. "Hurry up, Doc. It's pneumonia, I guess. Move up quick, if you've got to dress. I haven't the money, but I'll pay you soon—I've got some coming the first of June." You console the fellow the while you dress. The fee? Oh no, you cannot press. His wife is ill, and he's come to you, for help in his need—your friendship's true.

Your warm home you leave and clatter away, and when you return it is light and broad day. You have shunted the hand of the Reaper aside; Man's skill and worth have been met and tried. You may get your pay, and again you may not, but just at the present it's far from your thought. Poor Doc! you are richer than thousands of men who figure their worth in bank books with a pen.—Journal Indiana State Medical Association.

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Alcohol and Insanity.—While in almost every part of the civilized world alarm is felt at the increasing ratio of insanity in the population, there are some localities which, seem on the other hand, to be becoming less infested, so to speak, with the virus of mental disease. One of these appears to be the State of Kansas, which had in 1904, 56.2 commitments to its asylums per hundred thousand of population. In 1910 the number for each hundred thousand had fallen to 42.3, and in 1911 to 38.3, and the members of the State Board of Control and the asylum officials are said to credit this to the stricter enforcement of the prohibition laws of the State and the consequent diminished consumption of alcohol. Prohibition does prohibit in Kansas, it is asserted, and William Allen White, in a recent article in the Outlook, corroborates this statement. Of course, there must be some leakage over the border, but it seems to be a fact that Kansas is practically a "dry." state It is not surprising that insanity should decrease with the diminished consumption of an article of diet, or rather of indulgence, which is credited by alienists with the direct causation of at least 10 per cent of existing insanity—probably a considerably higher percentage—and which indirectly is a more or less important eitologic factor in a very much larger percentage of cases. The Kansas figures come reasonably close to those of the alienist statistician.—Journal A. M. A.

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CLINICAL NOTES

Prevention of "Inevitable" Digital Gangrene.—Within a comparatively short time it has been shown in practice that almost inevitable gangrene of the fingers or toes may be averted by making an incision in the pulp of the digit to allow the escape of venous blood, and then applying aspiration with a suitable dry cup. Our recollection is that this resource was the first practiced in a nearly severed finger, which of course must have been accurately splinted to render the treatment availiable. At a recent meeting of the

Kiel Medical Society (Kunchener medizinsche Wochenschrift, April 30), Koehler announced that the same plan of treatment had proved highly satisfactory in warding off gangrene from frozen toes, The patient had nominally frozen both his feet, but the two great toes and adjoining portions of the metatarsus were alone menaced by gangrene. These members showed every evidence of a freeze of the third degree. The skin was blue black, sensation was gone, needle puncture was not followed by bleeding. It had been decided to let the line of demarcation form, when the advice of Noesske to test the treatment already successful in the severed finger for all cases of threatened digital gangrene was recalled and at once carried out, with the result already stated above. Recovery was perfect from every viewpoint.—Medical Record.

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Remedy for Poison-Oak or Poison Ivy.—A hot solution of potassium permanganate made strong enough to be quite dark, rubbed in so as to reach the poison in the vesicles, is effectual. If the skin is broken, the solution should be quite dilute, and may be applied by means of a compress. The stain may be removed by applying a solution containing a mixture of oxalic acid and sodium hyposulphite, freshly made, say a tablespoonful each of oxalic and hyposulphite to a pint of water.—Life and Health.

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Heat Prostration.—Ice or cold applications to the head are almost invariably indicated. If the face is flushed, the skin red and hot, the pulse bounding and the heart aching tumultuously, the entire body should be rubbed with ice or bathed with cold water. Cold drinks are indicated. If the surface of the body is cool, use warm applications, mustard to the feet and internally hot drinks, whiskey, ammonia, etc.—Medical Summary.

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Several observers have recently declared that urinary antiseptics are much more effective if the urine be rendered acid. The power of hexamethylenamine is decidedly greater in acid than in alkaline urine, and its dose need not be so large.

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The high mortality attending removal of the iliolumbar glands in malignant growths of the testicle points to the advisability of a conservative rather than a radical operation.—American Journal Dermatology.

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THE MEDICAL PROFESSION.

Its Trials—Tribulations—Temptations—Mistakes—Seclusiveness—Secretiveness—Fetishes—Recognition of by the Public and Feeble Legal standing—Necessary Assertion of its Rights and Privileges, Socially and Politically.

DR. C. C. GODDARD, Leavenworth, Kansas.

Read before the Kansas Medical Society, May 1, 1912.

Probably the broadest in view, the most appreciative of the mysteries of the human mind, the most philanthropic, the least superstitious, the greatest lover of humankind, in a general way, is the genuine student and practitioner of medicine.

The profession requiring the greatest self-denial, arduous study and the longest time to acquire, is that of medicine, and justly so, as it is the profession that comes into closest touch with human life and "all its ills."

The law of the land demands that you shall go through the necessary purgation, that you may be freed, so far as is possible, of all the human dross and foibles of life and superstition, before you shall be allowed a chance to struggle for an existence in the race of life.

The law that requires so much of you to get ready, throws around you, for your protection upon your admission to the profession and its practices, the flimsiest of veils and in a manner turns its back upon you, disowns you, belittles you, thrusts upon and against you all of the spawn of ignorance, superstition and warped mentalities, licensed to prey upon the human family.

The executors, interpretors and exponents of this same law, that requires so much of you, are often the first to open wide their arms to these offsprings of ignorance and cult, take them in a warm embrace, cuddle and pet them, showering upon their unworthy heads, emoluments, place and endorsement, whilst upon the disciples of this most learned of all professions they heap contumely, insults and belittlements. So that you see although you have gone through the fiery furnace of trial, you are still within the crucible of power.

The reputable practitioner finds himself barred, by the tenets of his profession, from any opportunity to call to himself the attention of society whilst the same law allows all the charlatans and expounders of cults and isms to flaunt their achievements in the daily press; the press that has almost, if not entirely, supplanted the Bible in most of the walks of life. The press that has finally educated the public to believe that if a thing is valuable it is advertised and the public accept the Ads therein as being of the best because the "paper says so."

The modest position taken by the profession of being meek and lowly and of letting your work speak for you, are in my humble opinion based somewhat on the remnants of superstition and mysticism. Possibly the older men, remembering so vividly their own early start, desire that the youngster shall tread the paths they, themselves, have trod. Of course there is quite a difference between endeavor and success. For instance, the youngster may advertise his acquirements for doing surgery and is promptly squelched, disowned and knocked out, but the Mayo Brothers may run a full sheet telling of some of their "Wondrous Works" and we all smile and say, "bully boys"; and why? Because we know, that they know they are now independent of professional etiquette. We know their whole plant from foundation to dome is one great advertising scheme and our surgical friends rush to this mecca and proclaim to the world the superiority of the Mayo Brothers, even demand that they shall fill the highest office in our gift, and we feel well repaid if they accept and give us a smile of recognition. The discrimination is just the same as is shown by society at large in their treatment and recognition of the wholesale butcher as against his brother retail meat cutter, as between the shoe cobbler and the man that makes shoes wholesale. In other words it all depends on whose Ox gets gored.

Look back, some of you, and remember your advent into the arena. I can see myself sitting, waiting, starving, hoping, feeling and finally cursing myself for a fool, yet not daring to assert my-

self for fear of the frowns of my older brethern and if that was not a trial worthy of the martyrs, then it must have been paradise unrecognized. Look back upon the snubs of the old ladies, jeers of some of your older competitors, with their utter disregard of you, ethically, when called to one of your few cases, and tell me was it a trial or tribulation? Tell me did you feel like turning the other cheek or did you vow a vow to wait and when the time came to put in the knife and not only put it in but to turn it around? The latter probably,but when the time did come you thought better of it. Your finer nature conquered and you heaped coals of fire instead.

The numerous repellings and browbeatings you received, gradually froze out your impulsive ideas and you became a rather seclusive, reserved and thinking individual, requiring all of your training to accept anyone as being worthy of friendship, love or trust; but thanks to the furnace fires of your struggle, you came out without alloy, a being ready to forgive and forget, and to realize that

"There is so much bad in the best of us
And so much good in the worst of us
That it hardly behooves any of us
To talk about the rest of us."

Perhaps the fetish that the medical man unconsciously has ground into his mentality by study, association and schooling, is that of not advertising his accomplishments and probably this is as it should be, as it ill behooves a gentleman to walk about and call anyone's attention to himself by saying: "Behold! I am a gentleman" and as he would get the scorn of dumb people by such an act, the doctor needs be careful how he risks their good opinion by similar acts. The reason of the apparent necessity of some sort of advertising lies probably in the fact of the education of the public in homes, schools and newspapers. The people are in an age of materialism without much religion, reverence or self thinking.

The press is their *vade mecum* and any old thing will be swallowed by them if published therein. The science and mystery of life are left out too much in the education of the young, and as educators and the public at large are ignorant of its importance, it naturally falls to the profession to see to its being recognized as a necessary part of the acquirements of youth. Proper teaching in the schools along these lines for twenty years would about obliterate the present beliefs in all sorts of mysticisms and the future parents would be qualified to throw around their offspring a more perfect environment of protection against fads and fanati-

cisms and the gouhls that now wax fat and rich off an ignorant and gullible public, would become the "lean kine" instead. The education of the physician peculiarly fits him to be the conservator of public health and though his motives are often impugned, still it is his duty to stand for the right and let the natural detractors of mankind attack and misrepresent his acts. Medical societies are entirely too selfish at present. The doctors being sensitive and modest men do not readily take the public into their confidence, but keep their ideas and efforts within their own membership. In my opinion all county organizations should be required by law to hold certain public meetings to which every one would be welcome and at such meetings to take up certain subjects relative to the health and welfare of society and in these meetings the attending public should be allowed to participate, if they so desired, in arguments pro and con for the public good. These meetings would bring the people and profession closer together and the public would stand more ready to lend their support, privately and publicly, for the betterment of the commonwealth. The reason that the public at large looks askance at the profession is on account of the fact that they, as a people, do not comprehend or appreciate the motives of the medical men, asking for certain legislation. They cannot conceive of any one being so idiotic as to do something for the good of others without there being a motive of self emolument or political aggrandizment back of it as always is the case when they, the public, start anything.

If the doctors and people would get nearer together, the populace could better appreciate what was for his own good. The fact that the fakir, faddist, or ten-to-thirty-day-made doctor gets close to the people, prey and work upon their credulity and thereby get the people to allow the pretender to make them believe that the medical men are grafters and are enemies to mankind, is the reason they come so near succeeding as did the thirty day made doctors in the last legislature. They not only had lots of gullible people behind them, but had support on different branches of State Government, siding with their far-fetched, idiotic claims for recognition. Get next the people, show them by public meetings and fellowship that you have no black magic up your sleeve, or desire to mutilate their offspring and you will have the kind of backing that stands for social legislation.

Temptations come in many forms. Inherent in mankind is the temptation to take unto himself the love of self. Self adulation to swell up and expand under commendation by others and

have a feeling of self-satisfaction, no matter how fulsome may be the praise and no matter how well we know it is undeserved.

There is always the temptation to take advantage, at times unfairly, of one's competitors. to throw out the idea that we are strictly the best, that the public does well to be able to appreciate our great worth, to hint that had so and so been called it might have been different; to observe that "of course he's a good chap and is doing nicely, but, you know everyone cannot have the opportunities that some of us have had and though I don't mean any detraction, but, you know without being told and I need say no more."

In the profession, the great temptation is to drift apart, mostly on account of pin pricks, imagined slights, suspicion of other's motives, too ready an ear for the "dear public" to pour little bits of talk that has a sting. This is peculiar to the human race, an irresistible inclination to destroy reputation and play the Iago.

There is the great temptation to become a grub, to try and do all that can be obtained, to make one's-self a slave, to hang around the office day and night for fear some patient may drift away, to allow the indifferent public to make an ordinary drudge of one, to imagine that the people depend on and cannot do without your service, to imagine your taking off would be a great public calamity, whereas, if you would play dead you would find the same unstable public worshipping at other shrines in an inordinately short space of time, that being out of sight you were also out of mind. You would find, if you could come back after death, that the world still revolved, that the locality seemed to be doing about the same old thing in the same old way and that your taking off had not even jarred the machinery of human life. The temptation is to truckle to and slave for your patrons who really cared not whether you ate, slept, or were well or ill, so long as you could fulfill their selfish demands. A great temptation is to allow the public to ignore your dues, financially, and by so doing to foster the idea that your claims were secondary to all others, that your being paid made no difference to them and when they had no other place to put it, they might give you a dollar or two on account. You never hear of their treating a lawyer in any such manner. On the contrary, he is the first to get his due and the public is educated to the fact. One of the greatest of mistakes and temptations is to listen to the wiles of the fraternal orders which is usually made up of members of union organizations, whose fundamental pecularity is hatred of a "scab." These same men insist on em-

ploying you to do scab work for them, to prostitute your profes sion, to belittle your worth; these organizations are as well aware of your foibles and fears that they do not hesitate to come to you and ask you to treat them, and their families thrown in, at the munificent sum of 25c a month per family. They believe in getting something for nothing individually and by combining in numbers of two to three hundred or more, to quote you the lump sum per month you can get, not saying much of the per capita part of it, and you fall from your pedestal to partake of the fleshpots. You fear if you refuse your neighbor will accept and by so doing you allow these plagiarists of union seals and wages to do a thing they themselves would disown one of their own union members for doing. There is nothing that so belittles the profession in the minds of thinking people as this thing of labeling yourself a cheap article. If reputable men would all stand together and pull together, living up to their ideals, these mercenary organizations would be compelled to pay a decent wage for your services, but, so long as the so-called, standard men of our profession will ac cept such disgrace, they will prosper and finally succeed in mak ing the people believe that you have been robbing them for years by putting exorbitant prices on your services.

The people are gradually rousing up to the fact that a professional man that will accept such positions must be radically wrong some way, and it is not uncommon for them to refuse his services in their family whenever the existing affliction bids fair to be more than trivial.

If a member of the profession, accepting such places, could be debarred from association; and any other member meeting him in consultation while he was so debarred, could also be suspended, it would make a man think twice before accepting such positions, as he would hardly care to face trials of *mala praxis.* with all reputable physicians against him, and if we would all stand together, the so-called fraternal organizations would be compelled to pay regular fees for its members and they, the members, would feel better, the doctor himself would feel better and the grand old profession would not be compelled to blush for itself as at present.

One of the greatest mistakes the professional members make is not getting together, pulling together and fixing fair prices for all public positions—you never hear of members of the law accepting humiliating salaries from the public, and simply because they are a unit and all demand a decent price, and when the public has it to do they step up and pay the fair demand. We, as physicians,

have only ourselves to blame for the humiliating status of affairs, both public and private to-day.

Do you suppose that if the regular profession stood together as a unit that the chief executive would dare to insult them by refusing to select from a list, presented by the State Society for positions on State Boards; said lists submitted by request, and appointing men not even members of said Society? If he did he would well realize that his political career was ended with the term.

Do you suppose there would be any difficulty in getting decent legislation if the 2400 doctors in the state stood together demanding it?

Do you imagine that any State officer could be elected to office against the united efforts of the medical profession? Certainly not!

The mistake of the medical profession is in neglecting, almost entirely, the business side of the profession. They need to take more heed thereto and after they have given of their knowledge and skill without stint or price, they should see that the beneficiaries are made to feel their obligations on the financial side.

People would think more of us if we refused to be turned down unpaid, unappreciated and unthought of until disease or pain demanded they call again, but stood squarely and solidly for our rights and dues. The public, and individuals, as well never appreciate anything to be had for nothing, or next to nothing..

Counties and cities delight in playing doctors against each other when considered for appointment to official places therein. They expect us to take the humiliating offer, because if we refuse, the next man will accept. How much better if we stood together and fixed the salaries we must have at a decent amount.

The members of the law see to it that their profession is legally recognized and salaries fixed by status. We never hear of lawyers accepting such insignificant sums for their services and we would do well to follow the precedent. Our medical law is weak and needs correction and extension. The first thing needed is for the societies to all make it a point of issue to all work together and get up, in our own organization, a schedule of what is needed and when one is formulated and meets with general approbation for every member to get busy in politics, at least enough, to see that members are sent to Topeka that are friendly to our profession and not a lot of men that are inimical to our interests. Then you need a lobby, and a good one, at every session; a lobby that will look out for our interests and see that the whole legal structure is not knocked from in under, as was near the case in

the 1911 session. The Chiro-practics, free thought-faddists, Christian Divine and several other cults, are often the scalp of the medical profession and unless we wake up and get busy, they will have it before long. Nearly one-half of the last legislature were adherents of either osteopathy, chiro-practice, christian science or free medical thought. How do you account for this?

It is simply due to the fact that these organizations are united and working together, and they are accomplishing things, they are sending members to the legislature. The administration of the state to-day is much more friendly to osteopathy and chiro-practice than to the regular physician and his needs or comforts.

You are not appreciated in the high places and the fact is due to yourselves. You are dreamers and before long will expect to be fed as is the sparrow, as you take no heed for the morrow. Get busy for your own good. Stop pulling against your neighbor. Take "the beam out of your own eye" first. Humanity is fast bursting out of the Chrysolis stage. Mysticism will soon be of the past. Practical deductions are bound to supersede theories and dreams. We have a right to be proud of our grand, noble and self-sacrificing profession. This profession of good to our fellow-man. The calling next to Godliness. The profession endowed with the bravest, best, brainest, God-fearing, fellow loving, disciples of any profession on Earth, barring none. GET BUSY.

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SURGERY OF THE THYROID GLAND.

DR. D. W. BASHAM, Wichita, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

In summing up the surgical aspect of the therapy of goitre much difficulty is experienced in establishing the operation on a rational basis. In the case of Grave's disease the syndrome known as hyperthyroidism with its various manifestations constitutes the principal indication for surgical intervention.

In many instances pressure symptoms due to the size and situation of the goitre are added to those of hyperthyroidism. In these cases the distress is greatly increased. According to Beebe and Rogers, if the thyroid be treated with physiological saline solution two substances, a nucleo-protein and a globulin, may be extracted. Both of these substances contain iodin and both are present in iodothyrin. Notwithstanding, the physiological action of the two substances is not the same. The pulse rate is retarded by the injection of the globulin. On the other hand,

typical thyroitoxicosis results from the injection of the nucleo-protein. The globulin when secreted in excess provokes hepatic enlargement, thermal elevation, cephalalgia, and clay-colored dejectae. Rogers thinks that some goitres are due to an effort to overcome supra-renal secretion. Sajous is convinced that all the clinical manifestations of Grave's disease are the direct result of excessive production of adrenalin through over-stimulation of the supra-renal bodies as a result of the action of the iodin containing substances in the thyroid secretion. In other words, the iodothyrin of the nucleo-protein and of the globulin does not exert a direct action upon the economy but acts as an hormone augmenting the production of adrenalin, the absorption of which causes the phenomena observed in Grave's disease. Sajous persuades himself to believe that he has discovered a similar hormone in the colloid substance of the anterior lobe of the hypophysis cerebri.

The pituitary body, the thyroid, thymus and adrenals are connected by the cervico-thoracic sympathetic. The rational of the operation dealing with the cervical sympathetic in the thyroid toxicosis of Grave's disease and the kindred affections of the thyroid depends upon this anatomical fact. If these deductions of Sajous and others be correct surgical interruption of the sympathetic tract between the hypophysis cerebri, thyroid and supra-renal bodies, is the most rational of all procedures. This operation is in great favor in some parts of the world and has been performed a great many times. It must be remembered that the thyroid secretion may not only be too rich or too poor in iodothyrin but its character may be so altered as to modify the physiochemical nature of the active principle. In this way the economy may suffer from lack of these hormones or on the contrary the perverted secretion of the thyroid may exert a toxic action with manifestations differing from both hypo and hyperthyroidism. Acute congestion of the thyroid gland causes rapid absorption of the colloid iodothyrin containing substances attended by the phenomenea of thyroitoxicosis. This fact may serve to explain the presence of hyperthyroidism without visible goitre.

In consideration of what has been said we may conclude that the object of surgical intervention in the goitre of Grave's disease is to limit in some way the output of the iodothyrin containing thyroid secretions. The next question that arises is by what kind of an operation shall we attempt to accomplish this. There are three principal ways by which this may be done—thyroidectomy, sympathectomy and ligation of the thyroid vessels. As

to the choice between these three procedures much depends upon the individual case in hand. If the condition is an aggravated one ligation of the superior thyroid vessels is neither difficult nor dangerous. Amelioration follows as a rule. If it be found necessary to obtain further relief hemi-thyroidectomy may be done later. Hemithyroidectomy of the larger lobes with at most, ligation of the superior vessels of the other side, ought to be the operation of choice. The right side is usually the larger side.

Operations upon the sympathetic seem to be more dangerous than hemithyroidectomy. Unpleasant sequella may be observed after the excision of the sympathetic ganglia or resection of the trunk. Blindness has followed this operation, and congestion of the lungs and the eye is often observed. The operation upon the sympathetic for Grave's disease was first conceived by Jaboulay of Lyons, France. Jonnesco of Bucharest excises the superior sympathetic ganglia with a part of the trunk. The exophthalmus seems to be influenced more by the operation on the sympathetics than by excision of the gland. Hemithyroidectomy gives greater relief from the tachycardia and neuropathic phenomenae.

Notwithstanding the apparent logical foundation of the operation on the sympathetic the results have been altogether disappointing, and operations dealing directly with the thyroid found much more satisfactory.

The principal indications for operative interference as recognized by Kocher are:

1. Struma nodosa, where the nodules are in process of degeneration whether the nodules be colloidal, fibrous, calcareous, hemorrahgic or cystic.

2. Diffuse colloid goitre that does not respond to iodin medication and has given rise to functional disturbance.

3. All goitres that occasion marked disturbances by pressure.

4. All goitres that provoke serious heart symptoms should be treated by operation.

5. Struma profunda and substernal or intrathoracic goitre should be removed, especially if they are increasing in size, for if left undisturbed grave complications are sure to ensue.

6. Goitres beginning suddenly and growing rapidly with unusual form and consistence should be removed no matter what the age of the patient.

7. Goitres that are painful and sensitive to pressure are to be treated surgically. Kocher gives the contraindications to the operative treatment as respiratory and circulatory disturbances of long duration with reference to weakened heart action when the goitre is the cause of myocardial and renal degeneration, marked emphysema, obesity. If operation is contemplated in the presence of any of these conditions the patient must be kept under observation and treatment for some time in order to be able to determine if the goitre is the cause of his condition. In order for the operation to be successful operation should be resorted to before serious degenerative changes have occurred in the heart, kidneys, lungs or the nervous apparatus. According to Kocher the operative treat ment may consist in excision, Kocher's own method, enucleation, the method of Porta and Socin, resection as counseled by Mikulicz exenteration first done by Kocher, or lastly by ligation of the vessels, Wolfler's method. Excision is the method of preference, because it is at once the safest, easiest and most effective and satisfactory as to results and freedom from recurrence. The operation of enculeation is reserved for cases when there are isolated nodules to be removed, where the other half of the gland has been previously removed, or has become atrophied. Resection is only to be thought of in rare cases as in some exceptional examples of diffuse goitre where some special difficulty is to be overcome. A combination of two or more different procedures may be found advisable in certain exigencies encountered.

Exenteration which consists in incision and evacuation of the contents of the goitre may become necessary on account of adhesions that make removal impossible, in malignant goitres or inretro-sternal goitre where the goitre has become adherent and cannot be delivered. This is simply an emergency operation. Ligation of the arteries and veins of the thyroid is of great utility. This operation is indicated as a preliminary paliative operation in Grave's disease and in all forms of vascular goitre. All the thyroid arteries should not be ligated any more than all of the thyroid tissue should be removed. Ligation of the superior vessels is usually sufficient. Ligation of the inferior thyroid arteries is almost as difficult as removal of the gland. In the operation of excision the parathyroids must be respected and sufficient healthy thyroid tissue must be left to prevent cachexia struma priva. Theoretically it is not correct to practice trunk ligation of the arteries when performing thyroidectomy, for fear of obstructing the blood supply to the parathyroids and bringing about the same results as if they were removed. Kocher disregards this, and the

results of his work prove the wisdom of his course. The recurrent laryngeal nerves must be avoided. This is more easily done when the trunk of the artery is not ligated. Slight injuries to the recurrent nerve does not produce permanent damage. In adherent goitre care must be exercised in dissecting the growth away from the trachea. The trachea has been perforated when the dissection has not been done with proper care. In operating upon intra-thoracic goitres the pleura may be opened unless we use extreme care.

Post-operative complications do not seem to be more frequent after thyroidectomy than after other grave operations. Embolism is a rare post-operative complication. Tetany does not occur if the parathyroids have not been disturbed. Hemorrhage is rare, but may be a post-operative complication, especially where severe vomiting as a result of the anaesthetic occurs. Pneumonia does not follow thyroidectomy any more frequently than the other serious operations. The semi-sitting position after the operation is our best prophylactic against the occurrence of pneumonia.

Tetany seems to be a serious post-operative complication of thyroidectomy, and once developed, the treatment is very unsatisfactory. Lactate of calcium, the extract of the anterior lobe of the hypohesis cerebri, parathyroids and the thyroid gland are the principal agents employed in the treatment of tetany.

When myxoedema follows the removal of goitre it is because too much of the gland has been removed. Naturally, the condition is to be combatted by the administration of thyroid gland. The transplantation of thyroid has been successfully performed for the relief of myxoedema. Some exceedingly interesting investigations have been made of late by Marine and Lenhart for the purpose of determining the influence of the anatomical changes in the thyroid and lymphoid structures over the post-operative death rate of thyroidectomy. The greatest mortality was observed in the case with lowest iodin content of the thyroid substance. Also the excision of small cirrhotic glands, was accompanied by the highest mortality.

Among many very interesting observations offered by Crile, regarding the methodus medendi of the cure of the phenomenae of hyperthyroidism are his conclusions regarding the influence of ligation of the vessels and nerves at the upper pole of the gland He attaches as much importance to the interruption of the nerve path between the cerebrum and the thyroid gland as to the occlusion of the blood supply. Finally, he gives it as his opinion that ligation of the vessels and nerves with partial excision of the

gland constitutes our most reliable means of dealing with hyperthyroidism. As the matter now stands our most efficient therapy for goitre, as for cancer, rests in surgical intervention but it is not improbable that the future may give us a catolytic serum like that of Beebe that may remove both goitre and cancer from the domain of surgery altogether.

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CLOSER SUPERVISION OF PREGNANCY.

H. L. CHAMBERS, M. D., University of Kansas, Lawrence.

Read before the Kansas Medical Society, May 1, 1912.

I hope it will interest you to notice that notwithstanding the great development of special work in medicine and the careful cultivation of medical specialties by specialists, there yet remains one specialty which is rarely practiced by specialists. This specialty, obstetrics, is usually practiced by the general practitioner, sometimes worked as a sort of side line by the gynecologist, in some instances managed by old women of more or less experience, and in other cases is left to the vis medicatrix naturae—whatever that is. A specialty receiving such general and various support will have a cultivation which will be broad rather than deep, and obstetrics certainly follows the general rule. It seems to me that the public and the profession, especially those who are the logical leaders of the profession have come to regard any old way as good enough in obstetrics.

Let me illustrate the last statement: You remember an article on the management of labor, in the Journal A. M. A., last winter, wherein the author seemed to recommend practice that would be surgically dirty. When remonstrances were sent in, some of which criticized the editor for publishing such an article, there was an editorial reply saying that the advice was intended for the direction of the country practitioners. Now, when you reflect that all the so-called cities of Kansas are merely country places, when seen from the view-point of a man in Chicago, you see that the logical leadership of the profession does not expect much in the way of knowledge, skill, or care in the management of labor, and, I add, so much the less in the management of pregnancy or the puerperium.

If we make obstetrics to cover the ground commonly covered by the books on the subject, not restricting the application of the term to the mere delivery, then the weakest part in our average practice of this specialty is in the management and care of preg-

nancy. Lack of time and my scholastic limitations prevent me from telling you all the reasons that this is so, but I am sure that you agree with me without argument that it is so. The old idea that gestation and labor is a physiologic process, and therefore sacred, and not to be interfered with, should be considered as sufficiently exploded, and we should have both people and profession supporting the up-to-date doctrines of "efficiency"—the most and best results from the least cost and with the least risk. Apply the doctrine of preventative medicine—health and life insurance, if you please—to the care of pregnancy and spend some time, money and energy in seeing that it progresses properly and safely, and in fore-seeing and preparing for such difficulties as may be reasonably or positively anticipated.

Since the size and shape of the bony pelvis does not materially change, and since it requires no very special skill and no expensive apparatus to make reasonably accurate measurements, it seems to me every primipara should have the safe-guard of pelvimetry.

When I saw Mrs. E. R. for the first time in my life, when she had been twenty-four hours in labor, and learned by examination and observation that the head, though starting into the pelvis, seemed unable to enter and made out a too prominent promontory as the cause, I felt that both Mrs. R., and myself were at a disadvantage. A dead child was finally delivered instrumentally and remembering the comparatively rapid growth and rapid ossification of the last part of pregnancy, I recommended that, should another pregnancy occur, it be terminated by the induction of premature labor at seven or surely not later than eight months. (I could give better advice now.) The woman told me she had suffered a smilar experience before, and that another physician had then made the same recommendation, but that they believed such practice to be contrary to nature and wicked. Mrs. B's. case was similar. She had had two or three children, at least one of whom she lost. There had been no special preparation for labor nor supervision in pregnancy. I came to the case when labor had been in progress for several hours, and found an apparently favorable situation, occiput coming around from the left, and head entering pelvis. Good pains for an hour made no progress, and I finally made that that head was hanging or wedged on promontory, though I was unable to get my examining finger up to the point of impingment to confirm this diagnosis. Forceps were used to bring head into pelvis and delivery allowed to proceed in the natural way. Child was dead, and showed a depression in temporal region, which I believed to have been made by pres-

sure of the promontory. A contrasting case was a primipara whose pelvis had the normal width; interspinious, 25 c. m., intertrochanteric, 31 c. m; intercrestal, 27.5; external conjugation, 20 c. m., but was a little short in the diagonal conjugate diameter, 12.5 c. m. She was put on a modified Prochonow's diet for the last six weeks of her pregnancy, and delivered at full term of a living child. There was some trouble with the promontory, and the head showed a depression on the left side in fronto-temporal region, but this disappeared in the first month. Both mother and child seemed less vigorous than normal, but they eventually recovered and from five months on seemed as well as the average. In cases similar to this it might be especially wise to consider Wright's plan of inducing labor promptly at term, because each thirty days is now adding fifty per cent to the child's weight and the ossification is also increasing rapidly. I have no experience in the practice of it.

The children of diabetic mothers are not expected to show any special defects or diseases, but they do not thrive well and experience seems to show an unusually high mortality among them. A routine practice of frequent urine examinations would enable one to know of the condition and thus insure proper care. Mrs. M. had lost three children in the first few months of their respective lives, and there seemed no explanation for it. The supervision of her pregnancies had never included routine urine examinations, but in this last pregnancy such examinations showed presence of sugar to a degree beyond the so-called normal trace in the urine of a woman preparing for lactation. This was eliminated by reducing the carbohydrates of the diet. After delivery the mother was put back on full diet with no reappearance of sugar, and the child not only lived but seemed stronger and grew faster than other children of this mother who had survived. Another woman who had an annoying tachycardia, gave a history of one full term of pregnancy, with occasional traces of sugar in the urine, one that had to be interrupted on account of some trouble with her heart. In this pregnancy her urine showed a high sp. gr., 1040, and plenty of sugar. The carbohydrates had to be reduced nearly to the vanishing point before the glycosuria was controlled, and when this was accomplished, the tachycardia ceased to be annoying. Baby in this case had some difficulty in the first month but none afterward and seemed to become as strong as normal children.

The elimination of waste is recognized as important in all cases of whatsoever nature, and in pregnancy its value can scarcely be over-estimated. Whether or not it has any direct bearing on

the development of eclampsia seems to me uncertain, but there can be no doubt that it has an indirect bearing on this trouble, and that it has much to do with the success of any of the ordinary plans of treatment. Mrs. S., a primipara, had terrific headaches, obstinate constipation, something that I took to be a toxic amblyopia, more or less mental disturbance, a marked polyuria, ten to fourteen pints per day, and kept me in a state of chronically acute fright for months. Consultants agreed with me that her uterus should be emptied, but she indignantly refused anything of this kind and I got what comfort I could from the fact that her blood pressure did not exceed 120 m. m., hg. at any observation. The fact that the urea elimination did not exceed 45 gr. per day largely neutralized the calm that the sphygmomanometer reading gave. This woman carried her child to full term, had an instrumental delivery, a lacerated perinaeum, and a slow convalescence, but she and the child are both alive and happy.

If a labor should prove difficult or tedious, it will be easier to manage if the patient and her physician are acquainted and mutually understand each other. A closer supervision of pregnancy favors such an acquaintance and understanding, and is the last point I desire to make in my argument for such supervision.

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SOME EXPERIENCES AS HEALTH OFFICER.

DR. W. T. GROVE, Eureka, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

For years prior to 1893, Dr. F. W. Watson, a Civil War veteran, now deceased, held the position of county health officer, of Greenwood County, and was also the physician in attendance for the county poor, for which he received the annual compensation of one hundred dollars per annum.

About all the duties he had to perform were to receive and record the births, deaths and marriage certificates.

The county poor work located, largely, near the county seat, and the out-lying districts were attended, mainly by the other physicians.

Soon a change was wont to be made, and the officers were separated, the county work was divided into Commissioner's Districts. The doctor taking it, who had the most central-political honors being a consideration.

For a long time, all the health officer had to do, was to look

wise, receive 10c for each record, record same, and make a brief report to the county commissioners once every quarter. My first annual salary amounted to $45, a huge sum.

Soon the importance of quarantining came into vogue; and small-pox and diphtheria were about all that was quarantinable. At the close of the Spanish-American War, upon the return of the young veterans, there was quite an epidemic. Some had the so-called Cuban itch, some had small-pox, and others had other varieties of pox. The apparent fountain of procedure was in or near Topeka, and other large cities, but soon spread, and our county was not slighted.

At first, in 1900, some attention was paid to quarantine, and then it seemed a burden, and was thought too expensive by the commissioners, and the spread commenced in real earnest. It was no uncommon thing to have a small-pox case come strolling into the office, await his turn, or see him parading the streets.

All of a sudden, a howl came up, and the lid went on. I am not sure whether the present incumbant was in office at that time, or not, but the new style commenced, and then a howl came from the other side of the house. Right from the infected, came the demands for groceries, medicine, treatment and nursing. $3.00 and $4.00 per diem was common pay, and some were irresponsible ,and would get up dances, etc., to spread the infection more, and prolong the jobs, much to the dissatisfaction of the taxpayers. After so long a time, it was expelled for the time being. The hot weather seemed to be the wrong kind of an atmosphere for it to flourish in.

From time to time, through the preaching from the A. M. A., Dr. Wiley and other societies, we obtained more laws, and better ones; so that a quarantine meant something.

Finally, in 1901, we had some very adequate laws enacted, which were a great improvement, but still the laxness of the county attorneys, to enforce the law, in co-operation with the health officer, made it an ardous task to make the full force of the law felt.

Education of the public had to be accomplished, and it seemed to be a neighborhood method, when epidemics appeared in their midst.

Now we have more recent laws giving more power to the state board of health, and they are requiring the health officers to comply more strictly to the law. We have added to the list of small-pox and diphtheria, other quarantinable cases, which are

infantile paralysis, meningitis, chickenpox, etc., and put tags on the houses for many other diseases, not yet required by law to quarantine.

When I was appointed in 1911, we had to face an epidemic form of scarlet fever, and I had hardly gotten a start, when an outbreak of small-pox confronted us. We heard of one case, and to our suprise, it started a regular chase, and before we stopped, we uncovered forty odd cases, before we could even begin to check its spread. These occurred, largely, among families inter-related and from the same community, by Sunday and evening visiting—to while away the time. It was not until ninety-seven cases had been run down that we were able to control the spread.

Quarantine and fumigation were followed up, but small-pox can be communicated when housed up together, one to three days; prior to the papular form of eruption. So much for this.

One of the worst things to contend with, is a form of smuggling of mild cases in which no physician is called, and the folks try to evade a quarantine, and these mild cases set things going. Strange to say, some physicians seem to co-operate in the spread, by co-inciding with the infected parties, taking the grounds that it is a mild case and needs no quarantine.

Illustration No. 1.—Dr. M. reported a case of diphtheria to me, he quarantined, made three visits, and all of a sudden the father thought, that on account of the mildness of the case ,it was not diphtheria. Dr. R. was called in, who said, "It is not diphtheria at all, and you do not need to be quarantined," and they straightway tore down the card. Dr. M. heard of it, and notified me. The father was a strong "Appeal to Reason" reader, and tried the Socialistic style of disposal. I consulted the County Attorney, who told me to visit the case, and get swabs, and have the State Bacteriologist differentiate. Word came in about forty-eight hours, that it was diphtheria in a mild form, with mixed infection. I had re-quarantined, pending investigation, and notified trustees of the proceedings. Things went well for a few days, but soon the trustees and everybody began to get an airing, and the Appeal to Reason style would be mild when compared to this fellow.

I wish to say that we have an enthusiastic worker in the person of our county attorney, S. F. Wicker, as he is more than willing to co-operate at any and all times for the betterment and enforcement of the laws. He is ever ready to aid in the county health office work, wherein his services are needed. I always consult him, and am free to talk over any matter which comes up

and while he has been lenient on several occasions, yet he knows that to be lenient, makes bad discipline, and this puts the work of the county health office on a higher plane.

We, also, have to commend very highly, our county commissioners, as they have at all times and on all occasions, rendered every assistance in co-operating with us and have given valuable service.

I want to say that I do not have much trouble now, and on the whole the physicians report nicely, I have established the deputy system, in this way, when a quarantinable case comes up or fumigation, I make each doctor a deputy in his own work, having the same authority that I have, and share with him half the fee and all of the mileage ,and it works admirably.

Another thing, this allows the men in touch to oversee, and they become interested. I make a uniform price to everybody for work and material, whether they wish to furnish it or the druggist, and their bill is made out in itemized form, and I O. K. it, and they get their pay direct from the commissioners.

Many times the distance is so great, that it is not convenient to go, and again the deputy system saves a long haul and mileage, and cuts down expenses much to the satisfaction of the taxpayers and commissioners.

I could cite many funny and interesting things, as well as complexing and vexing circumstances, but I pass on.

One of the most perplexing problems, is the hotel and slaughter-house inspections.

Here again, we hear the old cry of, "Graft! Graft!" from the hotel proprietors. I shall admit, that with many, where the prices of lodging and meals are low, it is a hardship to exact too much. But discrimination cannot be resorted to, and we have to treat all alike. Only about 25% of the hotels last year, passed and received certificates or licenses to do business.

This year it is different. All have to comply with the law, and it is nice to have the state men send out their representatives to co-operate with us, and help enforce the law.

The fire protection, the roller towel, the drinking cup, cleanliness, in many ways, have supplanted the old indifferent methods. Many traveling men verify the statements that there is a great change, but one is handicapped if the state men and the county attorney do not co-operate.

Next in importance, is to see that all schoolhouses are fumi-

gated, wells cleaned, out-houses in sanitary condition, fences fixed, trees planted, public drinking cup abolished, etc., etc.

This has already counted well in curtailing much sickness in many localities.

I also have the county superintendent co-operate with me, and have him officially sign my letters of notification to the various school boards, and make each board give in detail in full, when and what they have done, and tell them if it is not done within a certain period of time, or good reasons given why it is not complied with, that I shall forthwith, proceed to do the same, and charge to the district.

Last year every district complied, promptly, and this year I will get it done with much less friction. I have already sent out one notice to the director of the district, to present to the school meeting, and the clerk and treasurer will each receive one later, as soon as we know the new boards.

Nuisances come to you galore, and I simply write to these fellows and cite the law to them, and usually have no further trouble.

It is, largely, a matter of education, and the manner in which you approach them. We have battles yet to fight, and it requires sternness, tact and skill. There are many trying things to absorb your attention and vex your patience, but the question of health rules, and their executions is a foregone conclusion, and like the advent and practicability of the automobile, they are here to stay, but they must be made sane and practical, and useful, otherwise, they miss the mark of prize and high calling, which is their reasonable service.

We all hail the time, when we will not be ridden over by politicians, and soon to see the day when we will have a National Department of Public Health and that the U. S. will be foremost in the laws of health, and will look to her people, with sagacity and scrutiny, which will cause her to be looked upon as a nation which takes pride in the health and long life of her people, and their safety in transportation, both transcontinental, as well as international, so that other nations can point to us with pride, that we have not run mad, solely on commercial lines and money making, but have become a sane and safe nation, looking well into our every economic well-being, and social happiness.

PELLAGRA.

DR. J. J. TRETBAR, Hudson, Kansas.

Read before the Stafford County Medical Society at St. Johns, Kansas, July 10, 1912.

This disease has been often discussed in our Journals, with some new views presented by various observers, yet I have thought it might be profitable for us to review the literature bringing it-up-to-date as near as possible, in a paper of this length.

In the past few years it seems that pellagra has been moving from the Southern states, northward and to the West. Not many cases have yet been reported in Kansas, but in Missouri they are not uncommon. In the state hospital of Illinois they are numerous, thus showing that in a short time we may expect to find ourselves contending with this same trouble, from which only three years ago, our state was free.

In this thesis it is my purpose to compare the difference in this disease, when such exists, between our American type and that of Italy. It may be well to state at the outset, that since the Italians have known this disease for a long period of time, I have rather inclined toward their views in this discussion.

Our text-books do not say much about pellagra. In the Practical Medical Series of 1911, may be found a fair description but for the latest work on the subject, it is well to read the public Health bulletin No. 48, revised edition of this year. From this publication I quote several times in this paper.

When pellagra was first recognized in 1735, it was thought to be a combination of scurvy and leprosy. Some 50 years later the skin symptoms were recognized as a part of the disease and named pellagra, meaning rough skin. During this time, and in the fore-part of the 19th century various observers had met the symptoms complex, and finally agreed that it was the same disease in different forms, in different parts of the country. In Italy the disease spread rapidly and was accompanied by high mortality. The United States remained free for a long time and until recently was practically unknown here. The American disease was identified with the Italian pellagra in 1908, although sporadic cases of a like nature were seen in eastern United States as early as 1864.

From this it will be seen that it may have existed, unrecognized, in the United States for 40 or 50 years. Yet we would not

like to give such discredit to the American profession. But in justice to our members it is well to add that the Italians had the same experience in establishing its identity in the 18th century.

The cause of pellagra is yet unknown, but it is generally regarded as a food poisoning, similar to ergotism and attributed to the use of corn as an article of diet. This view it still held in Italy, but in this country some try to attribute its cause to a certain protozoa or ameba. The Italians hold to their view because the disease was unknown where corn was not cultivated and used as a food.

Marzari had the idea that corn produced pellagra by not having certain nutritive principles. In 1810 Balardini conceived the idea that such corn probably was damaged by a mold or fungus. Later, Lombroso, who probably has done the most work on pellagra, confirmed the idea of Belardini viz., the corn idea.

The theories concerning the cause of pellagra are now divided. One school calling themselves Zeists (from Zea Mays), and those who oppose these or anti-Zeists. The Zeists contend that the disease came into Italy with the importation of corn; spread as the corn was cultivated and consumed, and that the disease is found only where corn is eaten, and that pellagra diminishes in a community where less corn is used.

There are several views as to how the corn produces the disease, but the theory mostly accepted at this time is the toxichemical one, and this is the one accepted by the Italian Government in its extensive prophylatic measures. In this theory they maintain that under the influence of saphrophytes (bacteria or mold), corn may undergo certain changes with formation of toxic substances. These organisms alone, they claim, would be harmless in man. Lombroso describes three substances, a red oil, a highly toxic substance, or pellagrosine, and a resinous substance. In experimenting with this pellagrosine on man and lower animals he finds phenomena allied to pellagra. It has also been shown that in the blood of pellagra patients, exists a substance which is antagonistic to the toxic actions of extracts made from spoiled corn.

On the other hand, the anti-Zeists contend against the corn idea, (1) Because of the extensive territory over which corn is, and has been cultivated and used as a food for many years without pellagra. (2) Numerous cases may be found in those who use no corn.

Some of the French writers regard pellagra as a symptom complex, which may arise in many cachectic states, and especially in alcoholic and insane persons.

In Germany they seem to give much credit to the rays of the sun as a causative agent. One German experimenter found that by feeding white rats on buck-wheat he could produce symptoms resembling pellagra, if the rats were kept in the sunlight, but those that were kept in the dark developed no such symptoms.

Since the cause of pellagra is unknown it is impossible to make positive statements, but it is claimed by those who have had much experience, that the disease is not transmissable from one person to another. Post-mortems of pellagrins usually reveal an atrophy of the heart, kidneys, spleen, liver, intestines and lungs. The nervous system is much affected as is demonstrated clinically by the result on the gastro-intestinal tract, the erythematous exanthem and the insanity in many cases.

This disease of all diseases is a chronic one, for seldom is it seen from the beginning. Sometimes it is divided into stages. The first stage has reference to the gastro-intestinal and skin symptoms. The second includes the cerebrospinal and psychic phenomena. The third is the terminal, characterized by cachexia.

Pellagra runs its course in a series of periodic attacks, occurring mostly in the Spring, sometimes in the Fall and subsides for a time, only to recur the next year. Following the prodromal period, there arises the gastro-intestinal disturbance, followed shortly by the erythema. In the beginning there may be a progressive weakness of the lower limbs, which may come on weeks before the characteristic skin lesions appear. But as a rule the patient presents himself as a full fledged specimen.

In the first stage the tongue is coated centrally and red and smooth at the tip and edges. Dyspeptic symptoms, with flatulence and pain in the abdomen are sometimes noted. Diarrhea is frequent, sometimes constipation. The temperature is usually normal as is also the pulse. Headache and insomnia are frequent. Mild mental weakness may be noted early. The erythema nearly always selects the uncovered parts of the body and is symmetrical. In the second stage the cerebro-spinal symptoms may increase to a certain tetanic spasm. The gait is paralytic. Hot and cold flashes are common. A salty taste has been so freqeunt in Italy as to call it "Salso". In the third stage the cachexia stands out boldly with the dementia, paralysis and other cerebro-spinal phenomena. Death usually follows with signs of heart weakness.

The erythema is a characteristic symptom of the disease. It usually comes in spring-time and spreads symmetrically on the exposed parts. It usually selects first, the extensor surfaces back of the hands and fore-arms, face, back of neck, chest and feet, later the flexor surfaces are involved. At first the skin becomes red with sensations of burning and itching. Puffiness may also be observed, all very similar to marked sun-burn. Large plaques may form, filled with serum and later dry up and scale. The redness may take a darker color. After the first attack the skin remains pigmented and with recurrence the skin becomes thickened and of a dirty yellow color. Then it may be rough and hard. Later the elasticity disappears, the folds grow deeper and painful fissures with thick crusts may develop.

As to the duration of pellagra we can say nothing definite, as it may be severe from the beginning and run a short course or may become gradually worse.

Since pellagra may be complicated with almost anything, we will not discuss the various forms; but it is well to remember that typhoid fever with it is not uncommon. And it must also be kept in mind that with the nervous phenomena there is a great tendency to suicide.

The diagnosis in a well marked case if advanced, should not be difficult, although early it may be hard to differentiate.

As to treatment not much need be said as we have no specific and must therefore be symtomatic. In Italy they advise an abundant diet with salt and meat whenever possible. Corn products are probihited. Some results have been had with the various arsenic preparations.

So far our community has been free from this disease excepting one case, that came under the supervision of the Stafford County physicians.

Mrs. X., age about 40 years, house wife, mother of four children. Contracted the disease in the South, came to Kansas several months before her death. Had all the symptoms of the advanced stages of the disease. Extremely nervous, delirious at times, slight temperature, erythema on hands and fore-arms, cachexia, finally exhaustion and death due to heart weakness.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

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EDITORIAL

Notice to County Secretaries and Councillors.—All matter for publication in the Journal must be in the hands of the editor not later than the last day of the month, to appear in the following issue.

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One of the most important problems in which the readers of the Journal ought to be interested concerns the development of the Society. How may the society be made more useful to the profession of the state? It is not enough that it's members may get together once a year and discuss a few interesting subjects. Such an organization is capable of affording it's members more benefits than this, and it is up to the members to determine in what direction it may serve them best. The establishment of the defense fund was a long step toward improvement, but that is only one of many ways in which the society may be made to serve its' members.

In it's early history the Kansas Medical Societv was particularly a scientific body. It's sole purpose was accomplished with the completion of each annual meeting. The duties of it's officers during the intervals between its annual meetings consisted solely in preparing the reports of the last meeting and arranging for the

next one. No matter how excellent this meeting may have been, no matter how instructive the papers and discussions may have been, and no matter how much real benefit those who attended the meeting and those who read the reports, may have derived, there remains the fact that during fifty-one weeks of the year the organization was idle, was performing no duties and showering no beneits upon its members.

Without trying to minimize the general good ultimate effects of our efforts to educate the people along medical lines and to secure certain desirable legislation, we must recognize that the only features added to our Society which are directly beneficial to its' members are the Journal and the Defense Fund. It does not cost us much, it is true, but it is a fair business proposition for one to get all he can for his money. Suppose it will cost a little more to add other features of benefit, if the returns are proportionately larger it is still a good business proposition and we will keep our plant busy.

A credit and collection bureau has been suggested as offering considerable benefit and is a feature which could be made practically self-supporting. It is certainly worthy of consideration. It would be possible, as has been demonstrated in other lines of business, to eliminate the dead-beat element from the physician's consideration and to follow up the travelling debtor who remains in one place only so long as his credit lasts.

Another feature which would not add necessarily to the expense of the society and which might be of great value to the members, is a lecture bureau. Through a committee appointed by the society, dates could be arranged for various county societies with prominent medical men so that the expense for each society would not be large.

Two or three of the smaller counties could arrange for a joint meeting and five or six society meetings and joint society meetings could be held in various parts of the state on successive evenings, so that the lecturer could make a tour of a few days or a week. No doubt some plan could be arranged by which the matter could be handled conveniently and inexpensively.

There are many other features which could be added to our society that would be attractive and beneficial but we have mentioned these with the idea of stimulating discussion along this line and bringing out other suggestions. Why not keep the organization busy all of the time?

W. E. M.

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Can the annual meetings of the society be made more attractive and more beneficial to the profession? For a great many years we have been satisfied with the same old plan of procedure. The secretary finds it difficult to get a sufficient number of papers promised to fill a two days program, but he must have at least fifty per cent more than enough for it has been the rule that many of those on the program fail to appear. In watching the progress of one of our meetings and noting the small number of members who hear the papers read and take part in the discussion, one naturally wonders if it is not possible to make this part of the meeting more attractive than the display of drugs and instruments and various other off-side entertainments.

On the few occasions when prominent surgeons from Chicago and St. Louis have been invited to take part in the program there was a very marked difference in the interest manifested. Evidently we enjoy hearing these men discuss medical subjects more than we do the men of our own society whose methods and ideas we are familiar with.

Why not try at least one meeting along the lines of a Chautauqua? Let us have all of the program made up of lectures by prominent men in the profession. We could have a two days session with four lectures each day, covering various subjects in surgery, internal medicine and perhaps some of the specialties. Some time might be set aside for reports of interesting cases by our own members but let the program be made up mostly as suggested.

It would be a course of instruction and would no doubt appeal strongly to the majority of our members. If the plan succeeds for a two days session it might then be extended to three days or possibly a week. Such a plan would perhaps entail some additional expense but no one will object to that if it be worth the money.

W. E. M.

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The medical profession does not have the standing that it should have. Why? Because the public have failed to sufficiently appreciate their service to humanity. Besides conquering and practically eradicating many of the devastating diseases of half century ago, they have lessened the mortality rate in many other diseases, so that the average life has lengthened about fourteen years per hundred in this country, which has also added many commercial advantages.

A strong reason for this lack of appreciation is due to the discord which has always been, and to a great extent still exists

in the profession, but fortunately through the harmonizing effect of Medical Associations, is rapidly lessening. The addition of the Medical Defense Fund feature to the Kansas Medical Society with the many other advantages make it imperative that every physician in Kansas become a member.

C. W. R.

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EDITORIAL CLIPPINGS.

Physicians and the Nervous Life.—The last three United States census reports gave the death-rate for physicians as higher than that of any other professional class. Nervous diseases constitute the most important factor in this death-rate. Commenting on these figures, W. K. Newcomb enumerates the probable causes for this unsatisfactory showing—the urgent call interrupting the moment of relaxation, the telephone bell breaking in on the hour devoted to quiet reading, the ever-present sense of responsibility and, most of all, what William James defines as "those absurd feelings of hurry and having no time—that breathlessness and tension, that solicitude of results, that lack of inner harmony and ease by which, with us, work is apt to be accompanied." Americans are inclined to measure efficiency subjectively—to make "the strenuous life" a synonym for "the efficient life." If a man reaches home at night a nervous wreck, he is apt to feel sure that he has spent his day effectively and well. Possibly even physicians, who from observation and theory know only too well the absurdity of this subconscious reasoning, are liable to be infected by it. The inexorable urgency of many of the physicians' duties will never permit his life to flow with serene and rythmic placidity; but doubtless it would be well worth while for most of us to spend a little time in analyzing and attempting to eliminate some of the causes for that wearing and useless haste and worry which shorten our days.—Journal A. M. A.

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Careless Critics.—A careless and ill-considered word of criticism about some other physician's work may be as successfully the cause of a suit for alleged mal-practice as malicious comment. Too many physicians unfortunately, are in the habit of looking somewhat patronizingly upon the work of their fellows and when this attitude finds expression in words, the impression made is distinctly unfavorable to the other fellow. Undoubtedly, in very many instances such implied reflections upon another's work

are thoughtless and careless; but the result is as bad as though they had been deliberate. The exciting cause of more than two-thirds of all suits for alleged mal-practice is to be found in the comment, malicious or careless, of some physician upon some other physician's work. As a rule the critic is not in possession of all the facts (one gets mighty few facts from a patient!), and when a suit is brought and he learns them, he quite frequently suffers no small discomfort and embarassment. We, as members of the Society, are safeguarding and defending each other's professional interests against unjust and generally blackmailing assault. Should we not be equally earnest in safeguarding each other's professional good name, and so prevent many suits that have no foundation in any actual failure to care for a patient properly? The careless critic who arouses discontent in the patient is more dangerous than the malicious one, for his motives are not so obvious and therefore not so easy to explain. When you feel like commenting adversely on some other doctor's work, just stop and think that the same thing may happen to you. And how would you like it?—California State Journal of Medicine.

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When Shall the Medical Profession Abandon Slip-Shod Business Methods and How?—Abbeville's Initiative.—If there is a single plausible reason why the doctor should not give serious thought and effort to evolve successful business methods, we have not heard of it. We believe it to be one of the most urgent reforms necessary on the part of the American profession. It is no longer considered beneath the dignity and high calling of the profession to either write a journal article or introduce the subject before a medical society, judging by the increasing number of allusions to business matters. The Editor attended a special meeting of the Abbeville County Society May 3rd, the meeting being called to consider the matter of fees. Besides the Editor, there were invited guests from several surrounding counties and towns. Drs. Chipley and Tate of Calhoun Falls, were the hosts of the occasion and tendered the Society an old-fashioned barbecue at the mineral springs in the neighborhood. It was evident that the large meeting was deeply interested in the subject. Dr. Chipley, chairman of the committee previously appointed to study the question of fees throughout the country, presented an admirable report, showing that the matter was considered vital in many sections. The Abbeville Society will continue to investigate the subject and we trust will publish its conclusions for the benefit of the State at large.

We wish to emphasize the point that every society should have a special meeting occasionally, and seriously consider the business aspects of the profession. We believe the time is rapidly approaching when the American Medical Association should set apart a section on economics. This action, of course, will not be taken until the demand warrants. Such endorsement would at once establish a bureau of interchange of ideas authoriative in character and bring about speedily a reform the individual is powerless to inaugurate.—Journal South Carolina Medical Association.

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SOCIETY NOTES.

1st District, C. W. Reynolds, councillor, Holton—No report.

2nd District, C. C. Goddard, councillor, Leavenworth:

The Osage County Medical Society which has not been very active for some years has recently been revived and meetings are now being held on the second Tuesday of each month. Dr. Smith of Lyndon is President and Dr. Curphy of Osage City, secretary. The last meeting was held at Burlingame, July 9th. A paper was presented by Dr. E. Olson on "Arthritis" and a paper by Dr. F. E. Schenck on "Preventive Medicine." The next meeting will be held in Scranton, August 13th.

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3rd District, H. B. Caffey, councillor, Pittsburg—No report.

4th District, W. E. McVey, councillor, Topeka—No report.

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5th District, W. E. Currie, councillor, Sterling:

PROGRAM OF THE HARVEY COUNTY MEDICAL SOCIETY FOR SEPTEMBER.

"FRACTURES."

"Open Treatment of Fractures, Dr. J. T. Axtell. Discussion, Dr. A. E. Hertzler.

"Diagnosis and Treatment of Fractures of the Upper Extremity." Dr. Max Miller. Discussion, Dr. G. D. Bennett.

"Diagnosis and Treatment of Fractures of the Lower Extremity," Dr. A. E. Smolt. Discussion, Dr. R. H. Hertzler.

F. L. ABBEY, Secy.

RENO COUNTY.

Dr. and Mrs. C. A. Monn returned from a months vacation.

Dr. and Mrs. H. J. Duvall have returned from a few days motoring in Oklahoma.

Dr. W. H. Williamson and family have returned from a motor trip through Colorado.

Dr. R. A. Stewart is enjoying a few weeks motoring in the mountains of Colorado.

The Reno County Medical Society will resume its regular monthly meetings the fourth Friday in September. The evening will be devoted to surgery. A good program is slated for the evening.

Dr. and Mrs. W. C. Bunduront of Patridge, Kansas, are the proud parents of a baby boy. Born August 11, 1912.

Dr. Lumm of Belpre, Kansas, is in the Stewart Hospital receiving surgical attention as a result of a ruptured gall-bladder. He is doing nicely.

Dr. Clemence Klippel attended the meeting of the Rock Island surgeons at Pueblo, Colorado.

W. F. SCHOOR, Sec'y.

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REPORT OF THE BUTLER COUNTY MEDICAL SOCIETY MEETING HELD IN EL DORADO, AUG. 15, 1912.

Ten physicians registered at the meeting.

Presided over by Dr. F. A. Garvin, president.

A paper on "Eclampsia" by Dr. Wm. McKinney, of Latham, was read. Discussion led by Dr. Anna Perkins, and participated in by all the physicians present.

Paper, "Purinemic Diathesis," read by Dr. C. D. Stahlman of Potvin. Discussion opened by Dr. F. E. Dillenbeck, followed by nearly all present.

Dr. F. A. Garvin Health Officer of Augusta County, gave a talk on the "Duties of Physicians to the County Health Board." Discussion by Drs. Bennett and others.

Two new members added to the society.

Next meeting in El Dorado, October 17, 1912.

J. R. McCLUGGAGE, Secretary.

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6th District, Arch D. Jones, councillor, Wichita—No report.

7th District, W. F. Sawhill, councillor, Concordia—No report.

8th District, O. D. Walker, councillor, Salina—No report.

9th District, C. S. Kenney, councillor, Norton—No report.

10th District, E. J. Beckner, councillor, Seldon—No report.
11th District, J. A. Dillon, councillor, Larned—No report.
12th District, W. F. Fee, councillor, Meade—No report..

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The medical society of the Missouri Valley, met in Council Bluffs, Iowa, Sept. 5-6.

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The Northeast Kansas Medical Society have post-poned their meeting from Oct. 10th to Oct. 24th. This was done on account of the meeting of the Medical Association of the Southwest at Hot Springs, Oct. 8-10th. The meeting of the Northeast Kansas at Topeka, promises to be way above the standard, papers having been secured from many prominent medical men of the middle-west. The program will appear in full in the October issue. The officers of the society are: Dr. Hugh Wilkinson, president; Dr. L. V. Sams, vice-president; Dr. C. C. Goddard, Secy-Treasurer.

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The annual meeting of the medical association of the South-West will be held at Hot Springs, Arkansas, October 8-10, 1912. An excellent program has been arranged and the physicians of Hot Springs have provided an elaborate entertainment. A rate of one and one-third fare for the round-trip has been arranged. To secure this rate ask your ticket agent for annual tourist ticket to Hot Springs and return. Following is the program:

Oration on Medicine.—Subject, "Some experimental Studies in the Treatment of Typhoid Fever, With a Low Caloric Food Value," Dr. M. L. Graves, Galveston, Texas.

Oration on Surgery.—Subject to be announced. Dr. J. F. Binnie, Kansas City, Mo.

Oration on Eye, Ear, Nose and Throat.—Subject, "Some Special Observations on the Mastoid Operation," (by invitation). Dr. Frank Allport, Chicago, Illinois.

Dr. E. D. Holland, Hot Springs, Arkansas: "The Necessity of Gastric and Stool Analysis in Digestive Disorders."

Dr. Joe Becton, Greenville, Texas: "Does Anchoring the Kidney Relieve the Neurosis?"

Dr. E. P. Bledsoe, Little Rock, Arkansas: Subject to be announced.

Dr. Thomas M. Paul, St. Joseph, Mo: "The Proper Lubricant and How to Use It in Urethral Instrumentation."

Dr. Bransford Lewis: St .Louis, Mo: "Stereoptican Lecture, Illustrating Genito-Urinary Surgery, Methods of Cystoscopy, Pathological conditions of Prostate, etc."

Dr. Alexander E. Horwitz, St. Louis, Mo: "Uncomplicated Fractures of the Tarsal Scaphoid."

Dr. E. H. Troy, McAlester, Okla: "The Treatment of Infections."

Dr. W. H. Stauffer, St. Louis, Mo: "Needless Traumatism in Rectal Surgery."

Dr. Frank C. Neff, Kansas City, Mo: "Personal Observations Upon the Use of the Caloric Methods in Infant Feeding."

Dr. F. W. Froehling, Kansas City, Mo: "Diagnosis of Gastric and Duodenal Ulcer."

Dr. G. Wilse Robinson, Kansas City, Mo: "Lesions of the Mid-Brain with Special Reference to the Weber, Benedict and Nothnagel Syndromes, With Report of Case."

Dr. A. L. Skoog, Kansas City, Mo: "Cerebro-Spinal Fluid, Diagnostics" (Will illustrate with slides specially prepared.)

Dr. A. K. West, Oklahoma, City Okla: "Really Medical and Surgical Traumatic Neurasthenia."

Dr. K. H. Beall, Fort Worth, Texas: "Pellagra."

Dr. J. W. Duke, Guthrie, Okla: Subject to be announced.

Dr. S. Grover Burnett, Kansas City, Mo: Subject to be announced.

Dr. E. C. Eberle, Dallas, Texas: Some Pharmaceutical subject.

Dr. John S. Turner, Dallas, Texas: "Meningitis."

Dr. Philip B. Matz, Leavenworth, Kansas: Subject to be announced.

Dr. H. O. Leonard, Kansas City, Mo: Subject to be announced.

Dr. T. J. Ernest, Topeka, Kansas: "Surgery of Obstetrics."

Dr. M. C. Porter, Topeka, Kansas: "Extra-Uterine Pregnancy."

Dr. J. C. McClintock, Topeka, Kansas: "Medico Legal Aspect of Fractures."

Dr. L. S. Milne, Topeka, Kansas: "Some Observations of Diabetes."

Dr. M. K. Lindsay, Topeka, Kansas: "Diagnosis."

Dr. Clarence E. Lee, Oklahoma City, Oklahoma: "La Grippe, Some of Its Most Important Manifestations and Complications."

Dr. L. J. Moorman, Oklahoma City, Oklahoma: "The Value of Tuberculin in Diagnosis."

Dr. R. L. Sutton, Kansas City, Mo: Subject to be announced.

Dr. P. T. Bohan, Kansas City, Mo: Subject to be announced.

Dr. C. C. Conover, Kansas City, Mo: Subject to be announced.

SECTION ON EYE, EAR, NOSE AND THROAT.

Chairman's Address—Dr. H. Moulton, Ft. Smith, Arkansas.

Dr. E. H. Carey, Dallas, Texas: "Report of Cases of Malignant Tumor Treated by the Starvation Method."

Dr. W. H. Luedde, St. Louis, Mo: "The Usefulness of the New Schiotz Tonometer with Demonstrations."

Dr. John O. McReynolds, Dallas, Texas: "Sympathetic Ophthalmia With Special Reference to the Influence of Foreign Bodies Retained Within the Globe."

Dr. Robert Cladwell, Little Rock, Arkansas: "Syphilis of the Nose and Throat."

Dr. J. H. Barnes, Enid, Oklahoma: "The Surgical Tonsil."

Dr. R. S. McGee, Topeka, Kansas: "Luxation of the Lens, Following Traumatism."

Dr. T. O. Edgar, St. Louis, Mo: "Topographical Anatomy of the Bony Labrynth."

Dr. L. Haynes Buxton, Oklahoma City, Oklahoma: Title unannounced.

Dr. M. F. Jarrett, Fort Scott, Kansas: Title unannounced.

Dr. W. M. Moore, Paris, Texas: "Conservatism in Surgery of the Turbinates, Tonsils and Adenoids."

Dr. H. L. Hilgartner, Austin, Texas: "Auto-Intoxication in Relation to the Eye."

Dr. R. H. T. Mann, Texarkana, Arkansas: "Bronchoscopy, Eosophogoscopy, Further Report of Cases."

Dr. Joseph Litchenberg, Kansas City, Mo: Title to be an nounced.

Dr. Theo A. Coffelt, Springfield, Mo: "Sub-Mucus Operation for the Correction of Deviated Nasal Septi."

Dr. J. Ellis Jennings, St. Louis, Mo: "An Operation for the Removal of Senile Cataracts before Maturity.

Dr. C. S. Petters, Eldorado, Arkansas: Title to be announced.

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NEWS NOTES

Dr. R. S. McGee of Topeka, has returned from a vacation spent in California.

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Dr. A. D. Updegraff formerly located at Anthony, has moved to Wichita, where he will limit his practice to surgery and surgical diagnosis.

Dr. E. C. Morgan and Miss Margaret S. Kehor of Clay Center, were married August 28th.

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Dr. C. L. Zugg of Kansas City, Kansas, who is doing post-graduate work in Chicago, will return October 5th.

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Dr. J. P. Kaster of Topeka, has been elected chief surgeon of the Santa Fe Hospital Association.

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Dr. G. W. Allaman of Atchison has been elected head physician of the Fraternal Woodmen.

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Dr. L. E. Haughey of Topeka, Kansas, has resigned as medical lecturer for the State Board of Health and has located at Courtland.

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Dr. B. J. Patterson of Rexford sustained serious injuries in a collison between his motorcycle and an automobile August 5th.

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Dr. J. H. Baldwin, an alumnus of Kansas University who is a missionery of Taien Fu, China, is spending a few weeks with his parents at Ada, Kansas, after which he will do post-graduate work in the East, returning to China in February.

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Dr. H. R. St. John of Alton, Kansas, who has been spending the past two years abroad doing post-graduate work in surgery, will return in October.

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Dr. John Sundvall of Baltimore, has been appointed professor of Anatomy in the University of Kansas.

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Lindsey S. Milne, M. B., Russell Sage Foundation, has been appointed Professor of Medicine in the University.

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The Kentucky State Board of Health passed seventy candidates for licensure out of seventy-seven who applied for permission to take the examinations. Dr. J. N. McCormack, secretary of the board, declared that the class of men who took the examination this year was the best that has ever appeared before the State Board of Health. In years past, he said, it was seldom more than 40 or 50 per cent of the applicants passed examinations. In view of the fact that seventy out of seventy-seven succeeded

this year, he declared that it was evident that the qualifications of physicians are growing better each year.—Medical Fort-Nightly.

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To Borrow Gorgas.—The Government of Equador has decided to clean up the port of Guayaquil, where yellow fever has existed for some time, and to that end has asked the United States to assign Col. William C. Gorgas, sanitary officer at the Canal Zone, with some of his assistants, to make a survey of the port and advise a plan to be followed. The request is under advisement and will probably be granted by special act of Congress.—Medical Record.

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Clinical Congress.—The third Clinical Congress of Surgeons of North America will be held in New York, November 11-16, The place of registration is the ball room of the Waldorf-Astoria, where the daily program will be bulletined one day in advance and where printed programs of each days' clinics will be distributed. The work of the congress will be divided into six branches, namely: general surgery, gynecology, genito-urinary surgery, orthopedics, obstetrics and eye, ear, nose and throat surgery. In the evenings literary and scientific programs will be given.

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OBITUARY.

J. Newton Rogers, M. D., University of Michigan, Ann Arbor, 1848; died at his home in Marion, Kans., August 19.

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REVIEWS.

Constipation and Headache in Women.—C. A. L. Reed, Cincinnati (Journal A. M. A., August 3), discredits the common view that the constipation and headaches frequently complained of by women with gynecologic derangements are due to the latter, and holds that the chief cause is to be sought in displacements or ptoses of the abdominal and pelvic organs. He has had in his practice so many cases where these symptoms persisted after all gynecologic indications have been met that he feels that the work of Glenard fairly supplies the missing link in the etiologic evidence. The reflex and pressure theories will, he thinks, have to be largely abandoned. The usual displacement is a general descent of the bowels by which the cecum finds its way low into the pelvis, lowering of the transverse colon and hepatic flexure with obstructive angulation there and at the splenic flexure. Reed does not say

that these displacements are always accompanied by the uncomfortable symptoms; in some cases they may exist with a fair degree of health, but the frequency with which their diagnostic importance has been confirmed by surgical explorations by himself and others, and the uniformity with which they have been relieved by correction of the displacements has convinced him that such ptoses are frequent causes of pelvic mischief and general disturbance of health in women. The practical application of these views in operations for uterine procidentia and in the use of pessaries are also noticed.

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Eggs by Enema.—Here is a valuable suggestion contributed by Ellingwood's Therapeutist: Nutritive enemata are not considered as much as they should be, because of the rarity of the cases in which they are needed. Past experiences have proven that eggs are quite readily absorbed by the mucous membranes of the rectum, but this absorption is promoted by the use of salt without irritation of the bowels. The eggs should be beaten thoroughly with about fifteen grains of salt to each egg. Cream may be added to this and all beaten together, but Prof. Zurich at one time depended entirely upon eggs alone. An hour before the enema was given the rectum was thoroughly washed out with a full, free flushing, and the injection was given through a soft rubber tube.

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Dangers from Camphor.—Happich injected camphor into rabbits and guinea-pigs and the results confirmed those reported in the literature in regard to the great difference in the effects of camphor when it is inhaled or injected into an artery or vein. He ascribes the difference to the neutralizing of the injurious influences of the camphor by glycuronic acid which is generated fresh in the pulmonary circulation by the combination of oxygen and sugar. When the camphor is to be injected into a vein or artery, the individual condition in regard to the presence of adequate amounts of oxygen and of sugar must be estimated. When either of these is known to be abnormally diminished, then the use of camphor should be restricted. This applies especially, he says, to patients in inanition, the insane, cancer patients, typhoid convalescents.—Kentucky Medical Journal.

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Chronic Constipation.—A. C. Reed, Tompkinsville, N. Y. (Journal A. M. A., April 6), describes the forms of chronic consti-

pation. A peculiar form is due to spasmodic contraction which occurs in lead poisoning and in neurasthenic and melancholic individual. Belladona is the best antispasmodic for these cases and oil enemas are also useful. Chronic habitual constipation, however, is mainly of two types—first, loss of normal irritability or motile irritability, and second, loss of normal stimulus. The first of these may be due to an abnormality in the mucosa, musculature or nervous mechanism. Mucous membrane lesions are seen in chronic intestinal catarrh and in atrophy of the mucosa, which may be of itself an independent infection. Peritoneal inflammation can also involve the intestinal muscle and paralyze it. Muscular insufficiency without inflammation calls for stimulating tonic treatment. Disorders of the nervous mechanism are difficult to determine and measures directed to the underlying nervous or psychic disorder are called for. Decreased normal stimulation of the intestine is largely due to an overconcentrated food-supply and diet, lacking in substances that exercise a mild irritant action, such as are found in the indigestible parts of the food, as coarse vegetables fibers, etc. The addition of these to the diet and regularity of habit are to be advised. According to A. Schmidt this does not tell the whole story, and overdigestion of the food is mainly responsible. The feces are hard and insufficient in amount and the proportion of bacteria obtained is less than normal. The tender cellulose of fresh vegetables has been found by Lohrisch to be more thoroughly digested in the intestines of constipated individuals than in those of normal individuals. Hence, Schmidt advises that a material less digestible than cellulose be added to the diet and concludes that agar-agar is the most suitable. When given dry in small lumps or in scale form it swells somewhat in the mouth, still more in the stomach and passes unchanged in the feces, which are softer and more quickly evacuated as a rule. It is best given in the scale form, a teaspoonful or more with each meal. It is tasteless and unirritating. Reed advises a careful routine examination of the feces in patients with intestinal disorders as facilitating an accurate diagnosis of the trouble and giving a rational basis for treatment.

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MISCELLANEOUS

The Tongue of the Wise Useth Knowledge Aright.—"Some physicians are so conscientious—and so tactless—that they think they must tell patients the whole truth when they believe they cannot recover, instead of giving them the benefit of the doubt,

for every physician knows that nearly always there is a doubt which way the case will turn. Cheerful encouragement has saved many a life by helping it to pass a crisis favorably, when the actual truth might have killed the patient or reduced his rallying powers to the danger-point."—O. S. Marden.

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The Ideal General Practitioner.—He is virile by virtue of his environment; he is self-reliant from his isolation; he is resourceful from necessity; he exalts common sense above fine theories; he deals with all conditions and preserves a breadth of vision, grasps general principles, and failing the finer technical knowledge of the specialist, is spared the distortion of his perspective. He knows his patient as a man and a friend and not a a commodity, and he it is who exemplifies best and most consistently that unselfish regard for others that glorifies medicine.—Meara in Boston Medical and Surgical Journal.

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A dispatch from Paris says: "Dr. Pierre Roux has communicated to the Academy of Sciences the results of experiments at the Pasteur Institute in Tunis with anti-cholera serum. This consists of culture of living cholera bacilli which, injected into the veins of several persons, conferred complete immunity. Dr. Roux believes that effective vaccination against cholera is within sight."—Medical Fortnightly.

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CLINICAL NOTES

One soaking of the hair in paraffin will accomplish in an hour what would take weeks to do with ointment in pediculosis capitis. The caution about the danger of artificial light must never be omitted.

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In clinical case-taking one of the most important factors is the duration of time that the disease has lasted. Lupus of the nose will not be called impetigo if careful attention be paid to the history in this respect.—American Journal Dermatology.

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For the removal of a stone, tumor or foreign body from an uninfected or mildly infected bladder, transperitoneal cystotomy

is preferable to the supra-pubic infra-peritoneal route, in that the bladder can be sutured where it is covered with serosa without subsequent leakage. With proper technic, including protection of the abdominal wound and the intra-abdominal field by packings, one need not fear peritonitis or wound infection.—American Journal Surgery.

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Rectal Hints.—In operating for fistula in ano do not hesitate to cut the sphincter, provided the line of incision is at a right angle to the muscle fibers. Incontinence will not result unless the muscle is divided obliquely.

Appendicostomy is indicated in inflammatory conditions of colon, knowing as we do, the futility of trying to reach these lesions with high rectal irrigations. The inflammation may be of a severity sufficient to require shutting off of the fecal current. In these cases an artificial anus is the most effective procedure, giving the affected area a chance to heal without the constant irritation of fecal matter. It is often surprising to see how quickly improvement or a cure takes place.

To control rectal hemorrhage knot together two strips of gauze, twist one in a spiral about the other, and introduce this into the rectum through a speculum, the knotted end first. Remove the speculum and pull the end hanging free, from the anus. In this way a solid plug of gauze is formed in the rectum.

Many fistula fail to be cured by operation because all the tracts are not opened. To obviate this, inject before operation a 50 per cent solution of methylene blue and hydrogen peroxide into the fistulous opening. Thus, the smallest ramifications of the tract are stained blue and cannot possibly be overlooked.—Jermoe Wagner, M. D., (New York), in International Journal of Surgery.

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Disinfection of the Hands by Tincture of Iodin and Decoloration by Sodium Bisulphite.—The employment of tincture of iodin to disinfect the surgeon's hands has not become general because of the difficulty of getting rid of the discoloration of the skin. The method of removing the discoloration by a solution of sodium bisulphite has been proposed by Dr. Taphanel of the Academie des Sciences. The method has the advantage of adding antiseptic action of the bisulphite to that of the iodin; moreover, the perspiration, which ordinarily necessitates washing during the operation, is suspended from an hour to an hour and a half.—Journal A. M. A.

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APPENDICITIS IN CHILDREN.

DR. ALBERT SMITH, Parsons, Kansas.

Read before the Southeast Kansas Medical Society, Ft. Scott, April 9, 1912.

This paper treats of some recent operated cases of my own and an analysis of the more recent literature of appendicitis in children. Appendicitis in children is characterized by a sudden on-set, rapid progress and obscurity of symptoms, it is a disease of the utmost importance, and it well merits more attention and study than has been devoted to it in the past.

Dixon reports the earliest case in a baby 24 days of age, the appendix was gangrenous. Other cases of infantile appendicitis are reported by Brumburg in a child 5 weeks old; by Dennis in a child aged six weeks. Burkholts reports 4 cases in infants, aged 12, 15, 17, 19, months respectively, while Springer has seen none younger than 3 years old. Our youngest patient was 4 years of age.

In 1000 cases McCosh found 1.7% in children up to 5 years of age. In 500 cases operated by Deaver the youngest was 21 months old. His statistics, however, place the frequency in the first 5 years at about 7%. Churchman thinks that infantile appendicitis deserves separate consideration from that occurring later in childhood, stating with much truth that the surgical problem of infantile appendicitis is that of diagnosis, and that the difficulty of diagnosis keeps up the mortality. Bramann asserts that the danger of appendicitis is greater in the first years of life than later and give a 50% mortality in all infants under 5 years that were present in a series of 117 cases in children. In those from 6 to 10 years inclusive the frequency jumps from 8% to 36% finally reaching 56% in those between the ages of 11 and 15 years. Our cases were between the ages of 4 and 16 years; this paper will

be confined to children of this age. As to sex, males predominate. In the series of Deaver, 315 were males, 185 females.

Osler says appendicitis is distinctly a disease of early life, as is shown by all tables of statistics.

The appendix in young children is situated higher than McBurney's point. The size and lumen are larger, as compared with the rest of the alimentary canal than in adults. The caecal end is funnel shape, which permits foreign bodies to enter and escape very readily.

The predisposing causes of appendicitis are said to be infectious diseases, family disposition, dental caries, and mechanical irritation. Of the infectious and contagious diseases, enteritis, colitis, scarletina, influenza, mumps, pertussis and chicken pox have been mentioned. Enteritis and colitis certainly produce congestion of the appendix, which, with superficial loss of epithelium may prepare the way for the infection of a deeper layer.

The exciting cause of appendicitis is of course bacterial, and usually the bacillus coli communis; other pyogenic organisms may act alone or in conjunction with the bacillus coli.

The pathology of appendicitis in children is distinguished from that of adult life by the tendency to early perforation and the frequency of spreading peritonitis, as the undeveloped omentum affords less protection against rapidly spreading peritonitis.

The differential diagnosis of appendicitis in children is often difficult, especially in children too young to state their subjective symptoms or to locate the pain and tenderness accurately.

There is usually a preceding gastro-intestinal disorder. The onset is rather sudden; the pains are violent and continuous. The clinical picture is alarming, convulsions are common. Children frequently complain of pelvic pain and a rectal examination should always be made, which gives tenderness, and rigidity upon the right side, frequent urination is a common symptom, the skin covering the appendix is extremely sensitive, a slight pinching of the overlying skin causes extreme pain. Suppuration is the rule.

Intussusception is common among children ; it rarely gives an elevation of temperature as an early symptom.

Particular stress must be laid upon the intestinal colic, also upon pneumonia. Many a child has been operated for appendicitis when the disease was one of pneumonia. In pneumonia in children the pain is frequently referred to the abdomen and when upon the right side to appendicael area, and if the diaphragm is involved in pleurisy, great tympany, fecal stasis and absence of

peristalsis may be present, in other words whenever a child complains of his abdomen always examine his chest.

Inguinal hernia, either strangulated or non-strangulated, may simulate appendicitis, twisting of the cord of an undescended testicle may also be considered.

The mortality remains more than it should be for 4 reasons; first, failure to diagnose the disease, sufficiently early; second, failure to recognize its gravity; third, postponement of prompt surgical intervention; fourth, incorrect treatment in the later stages of the disease.

It must be remembered that often cases in which the symptoms are most severe do not show lesions more grave than those in which the disease apparently had started as a mild process. Failure to recognize its gravity, any case of acute appendicitis seen early, should have prompt surgical attention.

There is no person who can say which case of acute appendicitis may progress to recovery and which may go on to abscess formation or general peritonitis and death. This has been proved so often that we have no right to postpone in any case. It is true that a certain number of cases of acute appendicitis will recover spontaneously under proper non-operative treatment only to have subsequent attacks. It is equally true that some unoperated cases will die, could we but differentiate the two classes clinically, our mode of procedure would be easier to establish. The only safe and proper course therefore, is to resort to prompt operation when a case of acute appendicitis is seen early.

We believe one-half of the cases of acute appendicitis would recover if not operated, but we know there are no symptoms that will tell when a case is approaching the danger line until it is extremely dangerous either to interfere or to wait. Our results justify such a statement as our mortality in acute appendicitis seen early, when the inflammation has been confined to the appendix, has been none.

The third reason for the mortality is our failure to recognize and act upon this proved fact in every instance.

Delay in operation is the most important positive factor in the mortality in acute appendicitis. The reasons for this are so well known that we need not mention them.

If the disease is attacked sufficiently early, the destructive and inflammatory processes are more likely to be limited to the appendix itself and easily removed. When operation is delayed the infectious organisms have time to penetrate beyond the walls of the appendix, enter the peritoneal cavity and give rise to diffuse

or localizing peritonitis. If these cases could be seen, diagnosed and early sent to the operating table, acute appendicitis would be robbed of its dangers.

The fourth great source for mortality in acute appendicitis in children is the incorrect treatment in cases which for some reason or other the disease has been allowed to progress beyond the confines of the appendix and we have to deal with an acute appendicitis, complicated by a more or less severe inflammatory lesion of the peritoneum.

The treatment of the appendix becomes then, not a question of the lesions in that organ, but of peritonitis, either the progressing or the localizing type.

The former is that in which the tendency of the process is to rapidly spread until it involves almost all the peritoneal surface. The localizing type is that in which the process tends to the formation of a localized peritonitis or a localized abscess, the former is liable to occur in children due to the lack of development of the mesentary. At the beginning of any peritonitis within the first 24 to 36 hours it has been shown that the process is unconfined, and lying free between the coils of the intestines, the formation of a wall of fibrin occurs at a later stage, any peritonitis at this stage is with few exceptions amenable to prompt surgical treatment. The mortality arises with rapidity if diffuse peritonitis of whatever origin, when present for more than 40 hours.

It is no doubt difficult to know exactly when an appendicitis passes into peritonitis. Our guide is what is known as the calm, when the pain and tenderness in the right iliac fossae suddenly subsides, also when there is a sudden drop of temperature. Deaver states one of the most important causes of the mortality in appendicitis is faulty pre-operative treatment.

This is the true field of medical treatment in this disease. It is the custom to administer a purge to all children who complain of pain in the abdomen.

The procedure among practitioners of giving a purge or some severe cathartic is responsible for a large percentage of deaths.

The physicians see so many cases of colic or enteritis which respond rapidly to a simple cathartic that a false analogy has been drawn in respect to its efficacy in appendicitis, except those milder cases of catarrhal appendicitis which are only a part of an entertitis or colitis,it is difficult to see any great value in emptying the contents of the bowels, but it is easy to see that in the severe cases to set up active peristalsis may mean to precipitate a perforation, to inhibit the formation of defensive adhesions and to

spread infective material throughout the peritoneal cavity.

In the initial stage before the diagnosis is readily made between simple colic and appendicitis, and before the advent of local pain, indicates that the inflammation has reached the peritoneal covering, it is not advisable to give a rapidly acting purge such as castor oil or salts after the pain is localized and nature is trying by stiffening the surrounding muscles to secure rest for the inflammed member,it is not proper to nullify her efforts from within by giving a cathartic. We believe we caused a perforation by giving a cathartic at this stage. If it is desired to move the bowels enema should be employed but give it gently.

Quiet rest for the inflamed focus should further be produced by withholding all food and liquid by mouth. An ice bag over the right iliac fossae will quiet the patient, inhibit peristalsis and discourage too many examinations.

No opiates should be given as a rule, an exception may be made to this rule, when operation has been decided upon and the patient is suffering to an unusual degree from nervousness and pain.

There is no way to tell the case that will get well from the one that will not. Medicines in this disease are out of place, appendicitis has been proven to be a surgical disease, therefore, the one rational treatment of acute appendicitis and especially in children is in operation, early and immediate if possible.

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VACCINES IN RELATION TO GENERAL MEDICINE.

DR. O. B. KIEHL, Pittsburg, Kansas.

Read before the Sautheast Kansas Medical Society, Sept. 25, 1912.

When Sir A. E. Wright of London, announced to the scientific world that he had discovered or perfected the vaccines or bacterins, there was at once started a great controversy, as is usual with new discoveries, and many eminent men of the scientific world took sides pro and con. However, after six or seven years work along these lines we should be able to deduce some salient facts, and to discard many ideas that have been promulgated and found lacking after a thorough trial. The bacterins are not one grand panacea for all ills as was at first thought by some, but we find that they have many uses both as prophylactic and therapeutic measures.

By the term bacterins we mean a suspension in 9% sodium chloride solution of killed bacteria. This suspension has been

standardized so that each cc. contains a definite number of bacteria.

A few words as to their preparation possibly will not come amiss. The cultures are made as usual, and incubated for twelve or twenty-four hours, and then the growth is washed off with a sterile 9% sodium chloride solution, giving us a suspension of living organisms in the salt solution. This suspension is then standardized by one of the various methods to determine the number of organisms contained in a given amount of the suspension. Now it remains for us to make the proper dilution so that each cc. will contain a definite number of the organisms, and then to sterilize the suspension. This is done by placing it in a water bath at a temperature of 60 centigrade for one hour. The temperature that just kills the organism is best, for if the heat is too intense it will destroy the active principles of the bacteria and our bacterin will then be inert.

Clinical signs are all that are needed for a guide as to the correct administration of bacterins. Of course if we could all make opsonic indices it would possibly add something to the ultimate results, but the procedure is so very laborious and time-consuming that the results do not justify its employment. In considering the clinical manifestations we must take both the local and systemic findings as our guide. The local signs are: Redness at site of injection, associated with a considerable soreness, with, at times, a slight oedema. The constitutional disturbances usually met with are a degree of malaise, slight headache, a slight rise in temperature and some general achiness. These all pass off in from twenty-four to thirty-six hours, giving way to buoyant, stimulating feeling.

The interval between injections is a subject demanding some consideration, because with each dose we have two phases: A negative and positive one. The negative phase is first present and it is then that we have the clinical disturbances manifested. After the negative phase, when the resistance is lowered we have the positive phase in which the resistance is being raised above a level at which the dose was given. This goes on for from three to seven days when the acme is reached and this is the ideal time to inject the next dose. So we see why the interval must be given consideration so that we will not give the doses too close together and superimpose one negative phase upon another. This explains why after a dose is administered we have the symptoms in many cases aggravated for the first two days because the resistance is lowered

and the invading organisms have full sway, thereby increasing the symptoms.

When we come to consider bacterins from a therapeutic viewpoint we must remember that the curative effects must necessarily be slow for the cells of the economy must respond to the stimulus furnished by the injections and manufacture the opsonin by means of which the organisms are affected in such a way that they become an easy prey for the phagocytes.

The bacterins may be used to advantage in all suppurative conditions which have a tendency to become sub-acute or chronic, except of course to tuberculosis infections and then they have a place in clearing up the mixed infections which so frequently coexist.

In a therapeutic way we have used the bacterins in acne, chronic bronchitis, chronic urethritis, furunculosis, carbuncles, both acute and chronic; otitis media, ethmoiditis, frontal sinusitis, pelvic infections in women, cystitis and pyelitis.

Out of a number of cases of acne we have to report excellent results in all save one case, which was treated for a period of one year with several intermissions in the treatment without any benefit. The treatment lasts for a varying length of time but usually about two months with an injection every four to seven days.

We have had very favorable results in chronic bronchitis in which the infection is usually badly mixed and require several bacterins to obtain the desired results. The following cases being rather unusual we will report more in detail. Miss L., American, aged 24 years. Three years ago had a double pneumonia with a very much retarded convalesence and continued expectoration, with loss of weight, a slight afternoon temperature and considerable pain in upper thoracic region. She was sent to Florida and remained one year without receiving any benefit. Two years after the penumonia an examinations of the sputum revealed an almost pure infection of pneumo-cocci. She was put on the pneumococcic bacterin and after eight injections was discharged as well, having lost all cough and expectoration and taken on considerable weight.

In chronic urethritis we have had a per cent of failures, but taken as a whole the results have been gratifying.

In furunculosis our results have been all that could have been desired. Out of several cases of varying duration we have had no failures. The following case in possibly worthy of some consideration. Mr. J., brakeman, aged about forty, has had furuncles for

a period of eight months. They were situated for the most part on the thighs and buttocks. A culture revealed a pure staphylococcus aureus infection. He received in all six injections of an autogenous bacterin, but while receiving the treatments he did not seem to improve as much as we expected, until the last injection, which gave rise to a rather profound reaction, when all the lesions present discharged profusely and cleared up in a few days. This was last April and he has been free from any further trouble to date.

In the otitis media cases the per cent of recoveries has been greater when the bacterins have been used in conjunction with the older methods than when medicinal agents were alone used. The acute or rather sub-acute cases yield better results than the chronic ones.

In ethmoiditis and frontal sinusitis we have found this method of treatment a very great aid in clearing up the discharge of pus after drainage has been established.

In the pelvic infections of women the bacterins have a place which is very important and many of these conditions can be cleared up that would otherwise require surgical intervention.

Cystitis and pyelitis offer very excellent fields for this treatment as evidenced by the following case: Mrs. M., aged twenty-two, white, has suffered repeated attacks of pyelitis for almost two years. Last attack was of eight weeks duration. Much renal pain on left side, with marked pyuria, temperature irregular, but never dropping to normal, occasional rigors and marked prostration. A pure culture of colon bacilli was found and a bacterin prepared. The first injection caused an amelioration of symptoms and after the second injection all symptoms disappeared, except the pyuria, which was much diminished. When the last treatment, the eighth, was given, the urine was found free from pus and bacteria and has so remained to the present time, nine months later.

We will now say a few words relative to the prophylactic use of bacterins. First and foremost, we have the vaccination against that dreaded scourge, typhoid. We, after having taken three or four doses of the typhoid bacterin have an immunity in all cases which is efficient in protecting us for an indefinite period against the ravages of this disease. The best authorities tell us that the immunity lasts for at least two years and in many of us possibly a permanent immunity is established. The danger in the administration of this remedy is nil if ordinary aseptic precautions are taken. If the bacterins had not accomplished any-

thing else, we would be well repaid for the effort that has been put forth in their production by the results obtained in the prevention of typhoid.

Many favorable reports are at hand relative to another dreadful malady which may be prevented by use of bacterins. We now speak of epidemic cerebro-spinal meningitis, and we have reason to believe that by the use of bacterins as a prophylactic we will have taken a long stride in doing away with this fatal and much dreaded disease.

In conclusion, will say that the bacterins have a definite place in our armamentarium for combating disease. I do not feel that they should supercede all other methods of treatment, but should be used as a very valuable adjunct in a therapeutic way.

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PROFESSIONAL CO-OPERATION.

THE REVEREND FLOYD POE, A. M. D. D.

Read before the Southeast Kansas Medical Society, Ft. Scott, April 9, 1912.

Every age is characterized by its own peculiar spirit. The Germans would doubtless call it the "Zeitgeist", while we would call it "The Spirit of the Times." Whether it is an age of discovery, or an age of literary activity, or an age of revolution, or an age of religious quickening, its spirit would permeate and influence the life of the people. Oftentimes I have asked myself the question—"What is the peculiar spirit of our times?" The answers that have come to mind are seemingly lacking in unanimity.

From the material side, this is an age of progress.

From the intellectual side, this is an age of hysteria.

From the spiritual side, this is an age of doubt.

And taking still another division of society, we have still different answers.

From the political side, this is an age of democracy.

From the social side, this is an age of publicomania.

From the commercial side, this is an age of advertisement.

Now in this seeming disagreement there is a startling harmony and unity. All these answers when taken and analyzed and then added give us this: This is an age of unrest with its consequent experimentation.

Progress, hysteria, doubt, democracy, publicomania, advertisement are all the outgrowth of unrest and each manifests itself in experimentation.

Now experimentation is not always scientific investigation.

A restless age is not necessarily a frivolous one. A restless age may be a questioning one and at the same time it may take itself seriously. The great difficulty with a questioning age is that it takes itself too seriously. The spirit of our times is a serious one.

A restless age is not always a severe age. It may manifest itself in painstaking effort to satisfy a longing after that which it has not. This manifestation may be honest, kind, even gentle. Of course this age like every other has its spiritual and intellectual incendiaries who would burn at the religious stake of freedom or the intellectual stake of reason, all who do not agree with them, but such are in the small minority. To-day, then, is not a severe day, but a trying one, nevertheless.

So, perhaps, we will agree that this is an age of unrest, but not a frivolous nor a severe unrest; a serious and honest age, taking itself seriously and believing itself honest.

But what has all this to do with the subject which we announced at the beginning: "Professional co-operation?" Kindly, brother, kindly, for our momentary departure has been an ascension in an intellectual balloon that we might get a wide vision of the times and their needs, but we will now come back to earth.

If it has been established that this is an age of unrest with its consequent experimentation, the question naturally follows: "How does this unrest and experimentation affect the clergy and the doctors?" The answer is to me a vital one. There is no more noticeable unrest to-day than that which is manifested in the attitude of thousands upon thousands of people toward your profession and mine. The current jokes of the so-called funny columns; the open insinuations; the bold effrontery; the sincere doubt; the quiet questioning, are all indications that multitudes of people are casting off what they call the "yoke of bondage" to the professions. It is not my purpose to enter into the merits of their doubts but simply to state them and thereby show how this age of unrest affects us. The somewhat successful attempt to label your national associations as "The Great American Medical Trust," certain court decisions requiring you to pay a state license fee to practice; frequent arrests and trials for malpractice in cases of unsuccessful operations; quiet stealing away to the quack, are indications of a certain public attitude toward your profession. While, on the other hand, sneers at religion; calling the minister a non-producer; absence from church services; desecration of the Sabbath Day; personal liberty organizations; independent religious movements, are indications of the attitude

of the people toward the ministry. But there is a greater multitude whose attack is simultaneously upon both professions; The Christian Scientist (so-called), denying the real personality of God, the actuality of sin, the flesh and blood of the body, and ignoring the supremacy of Jesus Christ, the efficacy of prayer and the necessity of the atonement;

The various schools of New Thought all the way from the Logomachies of Elizabeth Towne to Eleanor Reesberg with her annual May Metaphysical Festivals; Fillmore of Kansas City with his "Unity Magazine"; Elbert Hubbard of East Aurora with his Phillistine; Dr. Tilden of Denver with his "stuffed club", and a hundred other agencies of more or less public nature are decidedly outspoken against the professions of the minister and the doctor. Our mere sneering at them will but add to their popularity. There must be sane and unanimous co-operation if we would prevent the public from chasing every dangerous will-o-the-wisp that flies across its path.

The New Thought School openly says "we have come to believe that Jesus claimed no power which he did not mean us to share; that there is nothing inherent which separates us from Him; nothing in Jesus' power which men might not reproduce."

"Absent healing is just as effective as present healing. We treat people in all parts of the world without seeing them. People here in the city (Kansas City) call us by phone and get relief quickly. We can be reached day and night by letter, telegram or telephone, give name of patient and trouble in telegram."

Does this not provoke your risibles? But with your laughing stop and think while I read a little more? Here are extracts from letters written to a certain New Thought Leader in Kansas City:

Atlanta, Ga.—"You healed me of cancer of the breast." Mrs. L. L. B.

Laguna, Tex.—"Am growing stronger, enclosed a love offering."

Athol, Mass.—"I am almost entirely cured of kidney trouble." E. R. H.

Milwaukee, Wis.—"Rheumatism has completely vanished." E. O.

Pensacola, Fla.—"It is with pleasure and thankfulness that I write you to-night to tell you that after suffering untold agonies—even going into convulsions on Sunday with pain; yesterday between three and four o'clock that growth passed from me. It was a something about the size of a baseball, the character of

which we were unable to determine."—Mrs. M. R. (How strange that they didn't know.)

Osage, Iowa.—"The friend whom you are treating for paralysis is gaining finely."

Troy, Ala.—"I can hear much better."—Mrs. C. C.

Chicago, Ill.—"I am so much improved from indigestion and constipation that you may stop treatment. I enclose an offering." (Was he afraid he would get too well or that the waves of healing would have the same effect that the eternal fire had on She?)

Atlanta, N. Y.—"When I wrote and asked for treatment the pain in my side was gone before I mailed the letter." Mrs. A. K. (I think that is real funny.)

Kansas City.—"A lady who had been totally blind for five years was completely restored to sight." Mrs. Drake, 25 N. 15th Street, did the work.

San Francisco.—"I have quieted horses and put crying babies to sleep with the spoken word."

What wonderful cures! Do you suppose that a person thus easily cured will ever go back to you or go to church anymore? Yes, yes, they will some day come back to you broken in body and they will some day send for me to offer a few words of comfort and put them away in decency and respect. But, Oh, what they will have suffered in body and soul before they will return and confess.

Christian Science, though oftentimes listed under New Thought is entirely different in its claims. It denies the existence of body and pain and promises you release from disease by ignoring it and refusing to recognize it, while New Thought recognizes its existence and tells you that the healing life is within you.

Mary Baker Glover Eddy says in Science and Health, p 12, "Prayer to a corporeal God affects the sick like a drug, having no efficacy of its own, but borrowing its power from human faith and belief. The drug does nothing because it has no intelligence. It is a mortal belief, not Divine Principle or Love, which causes a drug to be apparently either poisonous or sanative."

On page 79 she says: "The act of describing disease, its symptoms, locality, and fatality, is not scientific. Warning people against death is an error."

If it were not for your professional pride and your fine sense of human sympathy I am sure you would like to experiment on some of these believers with morphine or strychnine or salts. I doubt if their faith would save them.

What I have just read is not the vagaries of a few people;

the people who believe these things are numbered in this country by the hundreds of thousands and their present growth is phenomenal.

At length have I mentioned these practices and views to show you that a large part of the present unrest is addressed toward the church and the regular practitioner.

I believe that the salvation of the people from the spiritual and the physical quack lies in the sane and sympathetic co-operation of the people of our professions of this country. Our union should be upon the very highest basis; that of the welfare of the public. It is not for our own sakes, but for the sake of the public. If it were for ourselves alone that we united, even that would be commendable, but we do not have to unite and remain in our professions for a living. The successful minister or doctor could certainly be a success in some other business, or he could out-quack the quack if money was all that he wanted.

Many years ago in the city of London, there was organized a club whose membership was composed of men, none of whom exceeded five feet in height. The published purpose of this organization was the promulgation of the theory, that the man small of stature was a more nearly perfect being than the man of large stature. The secret purpose of this organization could have been found in the old adage, "Misery loves company."

The men of the ministry and the men of medicine belong to no dwarf club, nor are they banded together for mutual condolence. They stand to-day among the most profound thinkers, the most advanced investigators, and the most unselfishly devoted to duty. They have never combined their forces for organized work, but there has always existed among the best of each profession a sound sympathy and profound respect for the men of the other profession. Each has done much in its own way for mankind and can do more in the same way, but they could have accomplished far greater results had they worked together with closer understandings and with a more intelligent comprehension of the fact that they were both aiming at the same result—a happy individual and a happy society.

The nobility of our professions is seldom realized by the populace. Should the ideals for which we daily strive be realized there would then be no need of us, and our two professions are the only two about which this can be said.

"Old Uncle Sam was employed by the Government to watch the big dam in the Rappahannock River, and kill the muskrats

so that they would not burrow though. On a certain day a busy passerby saw the negro sitting there and said:

"Well, Uncle Sam, are you looking for something to do?"

"No suh," answered Sam, "I'se gittin' paid fo' what I'se doin.'"

"Indeed," said the other, "and what may that be?"

"Shootin' the muskrats dat am underminin' de dam," answered Sam.

"Why, there goes one now!" exclaimed the stranger excitedly. "Why do'nt you shoot?"

"S'pose I wants t' lose mah job, suh?" answered Sam complacently."

And this is the standard of a certain type of man—he does not wish to do anything that will cause him to be out of his job. But if we succeeded to get all the world in perfect health and all things in perfect sanitary condition, and all the people good and moral, then would we be out of a job. Now the beautiful thing about our professions is that we are conscientiously and knowingly striving for this very thing!

Sooner or later the ministers and the doctors will be forced to unite not only for selfprotection, but also that they may the better carry on the great work which is theirs to do jointly,as well as separately. The day of such union cannot be postponed. It is at hand. There are evils now which we must combine to fight. They are in your profession and mine, and they are in no profession.

The public must be protected against the medical quack. Let us combine to do it. I presume it is not questioned that the medical profession has more quacks than any other profession. A man of splendid physique can never be called handsome with a countenance disfigured by cancer; nor can a woman be beautiful it matters not the perfection of her features if she is subject to a hideous deformity. The medical profession can never appear at its best until it rids itself of its cancerous growth—the quack.

There is the consumptive quack, the cancer quack, the tissue-paper quack, the "social disease" quack, the woman's friend quack, the dietary quack, the faith healer quack, the mind cure quack, and so on ad infinitum ad nauseum. In opposing these quacks who are intrenched in our business and social life co-operaeration and courage are required. Let your profession stand as an open and avowed unit upon the subject and then invite and receive the help of the ministry. Many of you have seen the names of ministers signed to testimonials of those who call themselves doctors, (and all of them regardless of their opposition to your pro

fession, love to shield themselves under its honorable title). In most cases those names are signed in ignorance of the true condition—and you are to blame for that condition. Many of those quacks have gotten into the church and some of them on its official board and from this safe vantage ground they have asked for and received social and professional recognition to which they were not entitled. Men of the medical profession, you would be wise if you would lend your influence to the minister and his ideals and in turn invite him into your confidence that he may intelligently share your ideals—we will all be pleasantly surprised in the harmony of our hopes.

Let the ministry see that the quack, who masquerades under the banner of humanitarism, is utterly selfish in his work. Who makes possible the digging of the Panama canal, the quack with his special cure for cancer or the regular physician who gives his life in the discovery of the cause and prevention of yellow fever?

Who is found on the battle field attending the dying and wounded, the quack or the regular doctor? Which would our government choose? Who would bravely go? Who is it leading and who opposing the fight against impure and adulterated drugs and foods?

Let pestilence invade any part of this country, or let a scourge of smallpox or yellow fever sweep any portion of our land and you will hear the government cry out for doctors! doctors to stop the ravages of these awful plagues. Even the daily press of the land, which fights the battles of the quacks for a consideration, will cry, "send us doctors!" Where then is your quack?

Where, oh, where, is your quack, when the poor patient comes back home from a false mecca with no money, no hope, and his life slowly ebbing away because he has let the operation day pass by while he was being plastered by burning remedies? Doubtless he is sitting in his office reading the confidential letters of other victims. Where, then is your doctor? Sitting beside the poor fellow, making his last hours as easy as possible and relieving the distress of the patient and the family with friendly hands.

Tell these things and a thousand others to the ministers and you will find them springing to your side with indignation and courage.

"Cleanliness is next to godliness" is the catch sentence to introduce us to the next evil which both professions must fight hand in hand. Spiritual degradation as naturally follows and supervenes upon physical degradation as night follows upon day. Bad sanitation induces bad morals as well as bad health. It is

often hard to disassociate dirt, disease, and death. A City Beautiful should be the common watchword of both professions. Observe in every pulpit a National Tuberculosis Sunday. Tell your minister about it, give him material and let him speak intelligently on the subject or else suggest to him that you will speak yourself. If you have a lantern lecture on cleanliness in home and street, give it in the church. Let ministers and doctors unite with a common purpose to have a clean city and therefore a better one in health and in morals. It will be no easy task to enforce an anti-spitting law, a garbage law, a bill-board law, but a bold and steady effort will get results. "Swat the fly."

The promotion of temperance is also the duty of the two professions. The minister voices from the pulpit those cutting words, "No drunkard shall enter the kingdom of heaven," while the doctor shows the pathological results, the unsteady nerves, the deadened sensibilities, the gradually lowering vitality, and the final end. The minister shows its moral obstructing power, the doctor its physical wrecking power, but both deal with the same ideal, the salvation of the man. In this the ministry and the medical profession will have to take very advanced ground. It will not be sufficient to admit the scientific correctness of the view that alcoholic stimulants are detrimental, we will have to refrain from using it ourselves or recommending its use. First abstain ourselves and then advise the same thing for others. I believe it is conceded now that is is not necessary to recommend whiskey to a patient, that there is a less harmful stimulant. If you have to have a substitute for yourself, make haste to find it. A drinking minister or doctor is a professional monstrosity. Let us stand "pat" on this proposition—temperance in our own lives and temperance for others.

And then follows the social evil. The minister should not hesitate to state from his desk that there is but one standard for both man and woman. He should demand social ostracism for the fallen man if that fellow insists upon it for the fallen woman. There should be no false modesty or mincing of words. The doctor should say that 80% of all pelvic diseases resulting in death is caused by gonorrhea; that 20% at least, of all blindness is due to gonorrheal infection of the new-born; that 50% of all involuntary childless marriages is caused by gonorrhea of the female organs. Publicly and privately the doctor should state the plain facts about sexual disease. Side by side the minister and doctor should fight the social evil found in our county high schools, our city schools and colleges. Minister and doctor alike, should

be startled by the statement that over 50% of all the women of the red light district were once upon a time members of some church. With great patience and firmness and kindness our two professions should co-operate against this national evil.

And now I mention a most noted example of public menace, "The Patent Medicine Evil." Long before Collier's took up this fight an elder of my church, a doctor; had interested me in this subject and I had written several articles upon it. This evil is made possible because of the medical profession. It grew out of certain quack remedies and doctors but it has become a public evil, and as such is to be fought by minister and doctor alike. It leaves as its victims drunkards, fiends, wrecks, hopelessly sick, and our common duty is to rescue the victim and punish the guilty.

You may be called "The Great Medical Trust," but there is an issue greater than jealousy or envy, it is the issue of honesty against fraud. These nostrum venders are liars, deceivers, hypocrites and as such the two professions should fight them as one.

Their present strength is made possible because of the long time silence of your profession. Had you spoken out as plainly at first as you are speaking now, there never would have been this gigantic, organized industry of to-day. In the early days it was no uncommon thing for the family physician to recommend cough medicines and soothing syrups. Some of you even to-day advise patent catarrhal sprays, and the like. Now that these people are so strongly entrenched we are beginning to attack them. Let us hope that it is not too late. If a man manufactures a remedy which he guarantees to cure consumption and does not know whether it will or not, then that man is a fool, lock him up. If a man manufactures a remedy which he knows will not cure consumption and yet which he guarantees to cure that dread disease, he is a knave, lock him up, but in a different place. There are so many evils attendant upon the manufacture and sale of patent medicines that it is difficult to recite them all. Absent diagnosis is as illogical as absent treatment. One is the patent medicine evil and the other the New Thought vagary.

No man in Cleveland, Ohio, can properly diagnose the ailment of a patient, unknown to him, in Fort Scott, Kansas.

Long drawn out treatment by patent medicine vendors prevents a correct and timely diagnosis by the physician, and finally it is too late and the patient rapidly fails. He has lost his chance for recovery.

The wholesale guarantee of certain remedies that cure almost

anything is a fraud and therefore a lie. The advice to take certain remedies which contain enough of drugs to create an appetite for more in order to fleece the unwary of their money is hellish—it preys upon the health and the hopes and the pockets of its victims.

Oftentimes these men who have grown wealthy at this business are members of churches and officers in those churches, and give large sums to missions and other religious purposes. This is embarrassing to the advancement of the church and trying to minister as well as the doctor. Then again there are very few church papers which do not lend the aid of their columns to the exploitation of their readers for this very purpose. A recent Presbyterian paper of wide circulation gave its entire back cover page to the advertisements of Bodi-Tone. I said "gave" when I should have said "sold." And that editor has frequently said that all his advertisements were investigated and presented on their merits. Does he know what Bodi-Tone is, has he ever taken it? Perhaps not, but he advises all his readers to try it—not in so many words but by selling it space in his columns. The ad claims that Bodi-Tone, compounded of 11 ingredients, will cure 20 different diseases! And in a religious paper. Can you not see how this great American fraud concerns both our professions?

Here again is our co-operation effective. If every Presbyterian physician would advise with and converse freely with his minister along this line and then the two would write to the editors of their papers telling them that they themselves would no longer subscribe and that they would no longer recommend them, do you not see that the editor would be forced to see the error of his way? Let us co-operate in stamping out this pernicious advertising for this is the stronghold of the evil. There are excellent papers being run without it. The Christian Science journals and the New Thought people in all their publications are showing us how to run successfully not only weekly and monthly magazines but even large daily papers without the aid of patent medicine advertisements.

And still the work in which we should co-operate piles up before us. If a man talks Divine Science to us, let us be familiar enough with its teachings and principles to refute them in a practical way. If medicine has no effect as they claim, let us challenge them to a trial of it. Let us bid them tell the truth about the dentists' chair, etc. In almost every library in the land you will find Christian Science journals and papers, but very few medical journals and other religious publications. Why not our litera-

ture? If our publishers were as wise as these people they too would send to every library their publications. If a certain party says that he has been cured by absent treatment let us visit him, and make examination, that we may talk intelligently about it.

In Independence, Kansas, recently, a Christian Science lecturer said something like this: "It is conceded that the real cause or the real factor of consumption was a consuming fear." And that statement went without a public challenge from any physician in Independence! It is high time to speak out.

And now the time is very ripe for the regular physicians to speak out along lines which various schools and sects are appropriating and emphasizing. I do not remember the time when I did not resent certain churches appropriating the cross as their peculiar emblem for all their buildings. The cross belongs to every church and as for me, Presbyterian though I be, I use it when and where I please. Let the doctor thus claim his own.

This study of human anatomy is a case in point. If anybody should know human anatomy under all conditions it should be the man who has attended a medical college for three or four years and then gone through a hospital as interne and then practiced for a longer or shorter time. And yet a certain school stands in the mind of the public as being the only school of practice that knows human anatomy. Why is this so? Because they talk it.

New Thought, Faith Cures, Emmanuel Movement, Christian Science, all are built more or less upon the self-hypnotic or autosuggestion basis. Where did they get it? Gentlemen, for years you have been giving blank tablets and your patients have been recovering. Modern movements have simply stolen your thunder and are making a loud noise with it. If suggestion is a good thing, say so, and do not permit anybody to appropriate it and claim the credit for it and leave the inference that you are ignorant as to its methods or results. Speak out with generosity about the truth in all schools, not blatantly, but firmly. Appropriate the good, oppose the evil. In this day of unrest the doctor and the minister must more than ever before, make themselves indispensable to society. If we are forceful against quackery, unsanitary conditions, intemperance, the social evil, public medical frauds, then will we receive our just reward of merit; but if we are unorganized, separated, actuated by jealousies and bickerings, and lose this great opportunity of united service for mankind, then shall we go our way to public disfavor and our murmurings will avail us naught.

But "Truth crushed to earth will rise again." Let us by

united effort be instruments in a Divine hand to help lift her to her rightful throne in our midst that all mankind may rejoice because of health and honesty and happiness.

"And united we stand."

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DEMENTIA GROUCHITICA.

DR. T. A. STEVENS, Caney, Kansas.

Fortunately, this is a very rare disease. It never attacks you and me; that it does exist, however, there can be no doubt. It sometimes attacks members of the medical profession; therefore, our remarks will be confined to its effects on the individual doctor and upon the profession as a whole.

Dementia grouchitica is characterized by three sets of symptoms:

1. ENVY.—The victim is chagrined at what he believes to be the good fortune of his competitor, who perhaps is no more fortunate than he, but smilingly goes on and does things, and receives favorable comment.

2. JEALOUSY.—He becomes suspicious that his competitor is taking unfair means, trampling upon his right, and pirating his business from him. He knows? that his competitor is dishonest, incompetent and unworthy. He resolves that he will have nothing more to do with him. Never speak of him, to others, except deridingly.

3. HATRED.—He not only detests his neighbor physician, but he concludes that something is wrong with himself; he has been too ethical, too honest; that only the blatant, incompetent, dishonest quack succeeds; that the organized profession is a frame-up to injure the honest doctor, that the independent is equally as inimical to the success of the medical profession. He believes that he will "throw ethics to the dogs," thus he goes grouchingly on, until he is regarded by the profession and the laity with much the same derision as he himself had looked upon them. He is in the advanced stage. He forgets that while other professions may lose their utility in the progress of things, the medical profession is the one indispensable thing. It has come to stay. The religious devotee may forget the priest and the altar; the lover may forget his impassioned vows; the mother may forget her babe after it is delivered, but "Man, smitten with pain, will not forget to seek relief."

4. TREATMENT.—There is no medicine known to medical science that will have the slighest influence upon this disease—even the "cup that cheers," will make the grouch more grouchy. Yet this disease is curable, but the remedy must be applied by the victim himself. He must turn himself around and go the other way. He should remember that the medical profession is composed of the best flesh and blood of the land, in this the best country on earth, where so many things are designed and provided for our happiness and comfort; inhabited in most part, by very lovely people. As the world grows older, there is more in it for the comfort and happiness of man . Modern comforts are abundant—people act and look more lovely—each year brings to us more to be enjoyed than its predecessor. He should seek the society of his professional brethern—none better can be found—and the grouch will disappear; discouragements will become fewer, and the world will look brighter and better.

"'Tis the coward who quits to misfortune,
'Tis the knave who changes each day;
'Tis the fool who wins half the battle
And throws all his chances away.
There's little in life but labor
And tomorrow we may find it a dream.
Success is the bride of endeavor
And luck is the meteor's gleam.
The time to succeed is when others
Discouraged, show traces of tire;
The battle is fought on the home stretch
And won 'twixt the flag and the wire'."

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It is extremely desirable to conduct a systematic and cleanly dissection when seeking a foreign body.

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Skin sutures must not be closely placed in fat subjects. Pro vision should be made for the escape of fat droplets.

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The ophthalmoscope, the sigmoidoscope and, of course, the cystoscope, belong to the equipment of every thorough surgeon, and their frequent use is an important part of the diagnostic examinations.—American Journal Surgery.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, J. E. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft, Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

LIST OF OFFICERS.—President, Dr. G. M. Gray, Kansas City, Kansas; 1st Vice-President Dr, H. G. Welsh, Hutchinson; 2nd Vice-President, Dr. Clemens Klippel, Hutchinson; 3rd Vice-President, Dr. G. A. Blasdel, Garnett; Secretary, Chas. S. Huffman, Columbus; Treasurer, L. H. Munn, Topeka; Librarian. S. G. Stewart, Topeka

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EDITORIAL

In the July number of the Journal, there appeared an editorial explaining the workings of the Medical Defense as is now conducted by the State Association, and I trust we will be pardoned for again referring to the same subject.

The first yearly report of the Defense Board was strong evidence of the success with which the plan works and should stimulate interest in the State Society, to the end that our membership should be doubled.

We are getting this protection without one cent of additional cost for membership and it is desired that the membership fee shall remain the same.

All of us know acceptable members of the profession who are outside of the State Association, and who, perchance, know nothing of the Defense feature.

There are within the borders of the state fully 1000 doctors who can easily be induced to join the State Society.

What is the best way to reach these men and get them within the fold?

One might say, let them them alone if they do not know enough to seek the Society, the Society should not seek them.

This is undoubtedly the wrong argument because many of these

men have the intention, the desire to join the Society but procrastination, busy life and a hundred and one things that come up in the life of a doctor causes him to neglect this important matter.

When one of us meets such a doctor say to him, "send in your application to-day," explain to him that the State Society will protect him from unjust suits and blackmail, and thus by deputizing ourselves to bring in new members, we will not only grow stronger, but will be able to keep the dues down to the present low figure.—H. B. C.

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The ex-president of the Kansas Medical Society stated in an argument before the House of Delegates that "the mission of the medical profession to-day is to prevent disease, rather than to cure."

Every practitioner of medicine should let that expression sink deeply into his heart.

It is with that banner at the head of the procession that we are to conquer the strong opposition that has recently sprung up in this Country in the form of "A League for Medical Freedom."

Whether the "Owen Bill" becomes a law or not, we are sure to have this nightmare to disturb our peaceful slumber in the future.

Composed as it is of patent medicine victims, Christian Scientists and a few misguided unfortunates they will continue to seek vindication.

It is astounding to realize to what magnitude the organization has grown in so short a time—they are not only organized for protection of their own interests but actually to discredit the medical profession and even make charges against us.

Dr. Murphy recently said, "the time for assumed impregnability of the profession and dignified silence regarding these charges is past," we must be prepared to meet these charges when they are boldly made before a public audience.

Prevention of disease is our mission and right here we leave the "League" with its cohort of isms and pathies.

This is the armageddon where we battle with the League. —H. B. C.

———o———

With the opening of the public schools, we are reminded again of the lack of systematic inspection of the eyes and ears of the school children of the state.

If Kansas ranks first in the proportionate number of educated people it would seem to be an easy matter to establish school in-

spection but the seeming lassitude in this important matter has developed an apathy that seems hard to overcome.

Politics has so obscured the horizon that people are shoved in the background; and unless an unusual awakening takes place we will have another school year to pass with its usual quota of suffering youngsters left to their misery by the indifference of those who should have held the welfare of the child first.

Much has been written upon this subject by men from all over the state and it is always freely and favorably discussed at the various society meetings, but effective work leading to the consumation of the plan has not been done and its most ardent supporters will have to take the initiative if we are to have a school inspection law; that means of course, the physician.—H. B. C.

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The following editorial appearing in the A. M. A. Journal, July 6th, 1912, serves to show that Kansas is not last by any means in progressive ideas. The Board of Health and the University both deserve praise for this innovation which will undoubtedly result in much good, being accompilshed. Other states have already taken up the idea and it will in all probability be nationwide in a short space of time.

Pulling Together in Kansas.—The Kansas State Board of Health and the College of Medicine of the University of Kansas held a summer school at the university, from June 10 to 15, for physicians and health officers. The program for the first day included demonstrations in the technic of water examination, lectures on water-borne diseases, sources of water supply and water purification. The second day's program contained a two-hour period on laboratory diagnosis of epidemic meningitis followed by lectures and demonstrations. The third day was devoted to a study of disinfection, ventilation and drug adulterations, and the fourth to laboratory technic on food adulteration and antitoxins, serums and vaccines. Saturday was given up entirely to clinics. The time allowed for this work permitted only the most general instruction, but even this is of value. Kansas has set a splendid example to her sister states in close co-operation between the state health authorities and the state university. The day has passed for standing aloof or for arguments over jurisdiction and authority. The spirit of the times is that of co-operation and mutual helpfulness. All the state agencies should work for the common good, and there is no work of greater importance than that for public health. If our state boards of health, state medical societies, state universities and educational institutions everywhere could be induced to

co-operate in the education of the public in sanitary matters, the results would redound to the credit of all concerned and would be especially marked in improved health conditions.

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The average layman, be he professional or business man, is ignorant along medical lines. All practitioners look alike to him, regular or irregular, osteopathic or magnetic, that is, so far as their system of practice is concerned.

Many who should know better rush after the latest fad and the bigger the fake the more followers. This is due to ignorance and they should be educated.

The American Medical Association through its Journal, and other publications, has done excellent work; but there is room for a greater educational work. Let the A. M. A. secure competent persons to write papers showing what osteopathy really is; and what chiropractice is doing; and what the ignorant healer of all denominations amounts to. Publish these papers so the county societies can buy them at cost and distribute them where they can do good.

We can not only educate, but beat the quacks at their own game. Educate.—W. F. S.

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EDITORIAL CLIPPINGS.

The Beginning of the End.—P. L. Dunlap—better known to the public as "Me-Too Dunlap"—has resigned from his position in the Bureau of Chemistry to take a commercial position at a higher salary than the government paid him. Dunlap, it will be remembered, was the plastic gentleman who took advantage of his chief's absence from Washington to prefer charges against him in the sensational attempt of the "interests" to oust Dr. Wiley from the Department of Agriculture. How trivial and unfounded the charges were is now history. The American public is to be congratulated on Dunlap's resignation. We trust that it marks the beginning of the end of a regime that has made effective work in the Bureau of Chemistry impossible. When McCabe, the self-confessed tamperer with official documents, and Wilson, the well-meaning but superannuated department head, also feel the spirit of resignation moving within them, a nation-wide sigh of relief will go up from those who have suffered from the comparatively unfettered machinations of the food-dopers, "patent-medicine" fakers and drug adulterators. —Journal A. M. A.

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A Heathen Sect.—A little child of five years of age died of

diphtheria the other day, after one "present" treatment and several "absent" treatments by a "Christian Science" mummer. The deluded mother stated that the child had been "in error." By error she explained she meant a "slight sin " In other words, this strange sect teaches that the Judge of all the earth will slay a five-year-old child for a slight sin. Has a heathendom ever evolved a more savage doctrine? It is akin to the horrible belief once taught that hell is paved with the skulls of unbaptized infants.

And these rivals of the Witch of Endor flourish exceedingly, fatten on the blood of the innocent victims and go unwhipped of the law because they call such a doctrine religion, and Justice keeps her sword in her sheath and smiles benignantly, if not inanely, on the lawless practices of this sect, because of the cloak of religion with which its votaries sanctimoniously cover their nakedness.—New York State Journal of Medicine.

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Human and Bovine Tuberculosis.—The final report of the Royal Commission appointed in Great Britain to study the relationship between human and bovine tuberculosis has at last appeared after ten years of patient study and experimentation. The earlier reports published by this body showed that almost all pulmonary tuberculosis is due to the human type of tubercle bacillus, but that the bovine type may cause abdominal or glandular tuberculosis, and it was found that children are especially susceptible to infection of this character. That the bovine type of bacillus may attack the lungs, however, is shown in the final report, by the fact that in one group of twenty-eight cases of pulmonary tuberculosis the bovine bacillus was found in two, while the other twenty-six showed the human type of organism.

On the other hand, of twenty-seven cases of primary abdominal tuberculosis, thirteen showed the bovine type of bacillus. Almost the same relationship existed between the two types in lupus. Twenty cases were investigated and of these nine showed bovine and eleven the human type.

In joint tuberculosis as in pulmonary tuberculosis the predominance of the human type of organisms is very marked—thirteen out of fourteen cases.

The practical deductions of this entire work are summarized by Hess as follows: "A considerable amount of the tuberculosis of childhood is to be ascribed to infection with bacilli of the bovine type transmitted to children in meals consisting largely of the milk of the cow." "Measures for securing the prevention of the ingestion of contaminated milk would greatly reduce the number

of cases of abdominal and cervical glandular tuberculosis in children, and such measures should include the exclusion from the food supply of children of the milk of the tuberculosis cow, irrespective of the stage of the disease."—Wisconsin Medical Journal.

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SOCIETY NOTES.

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First District, C. W. Reynolds, councillor, Holton:

A joint meeting of the Jefferson and Jackson county medical societies was held in Holton in August, the meeting was given over to the reports of cases. These were especially interesting on account of the difficulty of diagnosis of each case reported.

Another joint meeting will be held in Valley Falls in October.

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Brown county medical society will hold their quarterly meeting at Hiawatha in October.

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Second District, C. C. Goddard, councillor, Leavenworth:

The regular monthly meeting of the Douglas county medical society w as held in the Y. M. C. A. Building, Lawrence, Tuesday, October 1, at eight o'clock p. m.

Paper—"The Tuberculosis Campaign Among the Indians," by Dr. L. C. Day, physician in charge at Haskell Institute.

General discussion.

Business affairs and business methods relative to the medical profession.

E. J. BLAIR, Secretary. S. J. GILLESPIE, President.

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The Northeast Kansas medical society will hold its semi-annual meeting at Topeka, Thursday, October 24th, under the presidency of Dr. Hugh Wilkinson. An elaborate program has been arranged of considerable variety. The meeting will commence promptly at 1:30 p. m. The society will be entertained by the Shawnee County medical society. The program follows:

1. Inertia Uteri, E. W. Reed, Holton.
2. Flat-Foot, S. A. Hammell, Topeka.
3. Etiology of Eclampsia, L. V. Sams, Topeka.
4. The Blood in Disease, H. Milton Conner, Topeka.
5. Paper, J. C. Shaw, Holton.
6. Rabies, Wm. McDougal, Kansas City, Kansas.
7. Multiple Abscess of the Liver as a Complication of Appendicitis, C. C. Nesselrode, Kansas City.
8. Differentiation of Symptoms Located in the Epigastrium, E. E. Hubbard, Kansas City, Mo.

9. Plastic Surgery of Head and Face, Walter S. Sutton, Kansas City, Kansas.

10. Paper, W. K. Trimble, University of Kansas.

11. Ectopic Gestation, Diagnosis and Treatment, , C. J. McGee, Leavenworth.

12. Paper, S. H. Langworthy, Leavenworth.

The meeting will be held in the Commercial Club rooms and the banquet at the National Hotel.

C. C. GODDARD, Sec'y.

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Third District, Dr. H. B. Caffey, councillor, Pittsburg:

The Labette county medical society met at the residence of Dr. J. S. Dobson in Edna Wednesday evening, Aug. 28th., most of the doctors coming by automobile.

A number of interesting clinical cases were presented, the most interesting one being a case of spondylosis rhizomelique, presented by Dr. Elmer E. Liggett of Oswego.

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The Southeast Kansas Medical society held its semi-annual meeting in Pittsburg, Wednesday, September 25. Dr. Hugh B. Caffey of Pittsburg presiding.

The entertainment was under the auspices of the Crawford county medical society.

The morning was spent at the Mount Carmel, where Drs. Gibb, Graves and Smith held some excellent surgical clinics.

The literary and business session was held in the Masonic Temple.

The program was excellent every paper being instructive and enjoyable.

Dr. J. E. Sawtell of Kansas City, Kansas discussed "The Conservation of the Ethmoid. "

Dr. C. C. Conover of Kansas City, Mo., held a very interesting heart clinic; examining and discussing a number of cases.

This part of the program was a very novel feature and excited very favorable comment.

This was one of the most successful meetings of this society, about 60 physicians being in attendance.

The next meeting will be held in Parsons some time in April.

JOHN D. HUNTER, Secy.

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Fourth District, W. E. McVey, councillor, Topeka:

The Golden Belt medical society met at Wamego, October 3, 1912. The following program was given:

Paper—"Tuberculin Therapy—With Report of Case," Dr. Robert Leith, Manhattan.

Paper—Dr. L. R. King, Junction City.

Paper—"The Diagnosis of Breast Tumors," Dr. A. E. Hertzler, Kansas City, Mo.

Paper—"A study of the Elbow Joint in Relation to Its Most Frequent Injuries," Dr. W. C. Lathrop, Salina.

Paper—"Vaccine Therapy," Dr. Wm. K. Trimble, Kansas City, Mo.

L. O. NORDSTROM, Sec'y.

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Fifth District, W. E. Currie, councillor, Sterling:

The Marion county medical society met in regular session on September 11, 1912, at Hillsboro, Kansas. Owing to rain and muddy roads attendance was small.

The society elected to membership, Drs. J. J. Entz, of Hillsboro, Dr. Brakibill of Florence, on motion of Drs. H. Brunig and P. S. Wagar respectively.

Members present: Dr. H. Brunig, President; C. P. Brunig, P. S. Wagar, E. S. McIntosh, B. P. Prather, R. M. Reigle, H. M. Mayer, C. L. Appleby.

Next meeting Marion on November 13, 1912.

C. P. APPLEBY, Sec'y.

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Program of the Harvey county medical society for October:

Dr. M. L. White, "Acute Intestinal Diseases of Children," Discussion, Dr. L. P. Smith.

Ezra Branine.—Paper on "Medical Jurisprudence."

(Speaker to be Supplied.)—"Nervous Diseases."

F. L. ABBEY, Sec'y.

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A Congress of Surgeons in New York.—The third clinical congress of surgeons of North America will be held in New York from November 11th to 16th, under the presidency of Dr. Edward Martin of Philadelphia. The work of the congress will be divided into six sections, as follows: General surgery, gynecology, genitourinary surgery, orthopedics, obstetrics and eye, ear, nose and throat surgery. The evenings will be devoted to the reading and discussion of scientific papers.

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The American Association of Railway Surgeons will meet in Chicago, October 16-18th.

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The Mississippi Valley Medical Association will meet in Chicago October 22-24.

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NEWS NOTES

The Kansas State Board of Medical Examination and Registration held an examination at Topeka, October 8th.

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A Clinical Week.—For the week preceding the meeting of Mississippi Valley Medical Association in Chicago, October 22-24, and for two days following the meeting, a schedule of clinics is being arranged, to include medicine, surgery, special branches and research work in laboratories.

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Dr. J. G. Messeldine and Dr. A. R. Nash have recently located in Parsons and become members of the Labette county society by transfer.

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Dr. Geo. S. Liggett of Oswego is at Sulphur Springs, Ark., in search of relief for an aggravated kidney trouble.

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Dr. W. L. Hopper of Fort Scott, has just completed the erection of a splendid flat near the business district of the town. It is a two story brick and stone building with two separate apartments upstairs. one of which the doctor and his family occupy and the lower floor is divided up into suites for use as doctors' offices. The entire arrangement is original with Dr. Hopper and is the most modern and sanitary flat to be found in this section.

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The Northeast Kansas Medical Society will meet at Topeka, October 24th. Program appears in the society notes.

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Dr. L. Miesse of Pittsburg, has gone to Cheyenne Wells, Colo., in search of health. The doctor has been failing for some time and it is hoped that he will soon be restored to a normal condition.

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Dr. P. A. Harper of Pittsburg is expected home in a few days from an extended visit to Boston.

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Dr. C. Mart Montee of Pittsburg, is moving into his beautiful new home in Stilwell place.

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Dr. Wm. V. Hartman, a recent graduate of Tulane University, has located in Pittsburg, and will engage in a general practice.

Dr. O. B. Kiehl and Mrs. Kiehl of Pittsburg, have returned from a lengthy vacation "in the hills of old Arkansas."

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Dr. W. E. Knox of Norcatur spent the month of September in Illinois, visiting relatives.

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Dr. C. W. Cole of Norton attended the meeting of the Rock Island surgeons in Pueblo.

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Dr. R. M. Tinney of Kirwin, secretary of the Philips County medical society has located in Norton with offices in the Moulton Building.

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MARRIAGES.

Lieut. George Burgess Foster, M. C., U. S. Army was married September 4th, to Miss Sara Ellis Thomas. Lieut. Foster is stationed at Leavenworth.

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Dr. Elmer Andrew Miner of Independence was married September 19th, to Miss Eugenia Mason of Chicago.

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Dr. Jacob Hinden and Miss Myra A. Marvin of Strong City, were married at Kansas City, Mo., August 27th.

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Dr. P. Reynolds of Horton, was married to Miss Ora Grandstaff of Atchison on September 17th. They left immediately for a trip to the West Indies and Panama.

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OBITUARY.

George S. Morris, M. D., Medical College of Ohio, Cincinnati, 1181; was found dead in his office in Arkansas City, Kan., July 26, from cerebral hemorrhage, aged 61.

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Henry Smith Atwood, for nearly fifty years a practitioner of St. Louis, Mo., Pittsburg, Kan., and Galena, Kan, died at his home in Galena, July 25, from senile debility, aged 84.

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Nathan Smith McDonald, (license, Kansas, 1901): a practitioner since 1868; died at his home in Climax, August 20. Aged 67.

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Dr. P. M. Daily of Beloit, Kansas, died at his home, September

16th, from angina pectoris. It is with profound sorrow that we chronicle the death of Dr. Daily. The profession of Kansas has suffered an irreparable loss. He has been a guide and helping hand of the State Society for many years and his wise counsel has always been sought and his guiding hand always pointing the proper road and direction to follow.

It was indeed an honor to have known such a man whose ideals were of the highest and whose life was an example for all to follow.

He was known by every member of the state society who has attended any of its meetings during the past decade.

He served as councillor from his district for many years and also served a term as its president. He was the organizer of the Mitchell County medical society and served as its president.

His life was a fruitful one in all of its walks as a physician, a teacher, a citizen and a man he more than filled his place.

The following is taken from the Beloit Call:

Francis M. Daily was born September 10, 1854, on a farm near Centerville, Iowa, where he grew to manhood, and after his graduation from the Keokuk Medical College, he returned to his home town and for a year practiced there. In the year 1879 he came to Kansas and settled at Scottsville for practice.

Some years later he opened an office in Beloit and in 1892 moved with his family to this city, where he has since carried on a large practice as a surgeon and physician. His practice becoming so large that it was impossible for even a man of his power and skill to attend to alone, he, thirteen years ago, became associated in business with Dr. E. N. Daniels and they have since conducted the office of Daily & Daniels, which is known all over northwest Kansas. Early in June of this year Dr. Daily's health failed him to such an extent that he gave up his practice and has since with rare exceptions been kept at home. While his many friends knew that he was in poor health, but few of them knew that his condition was so serious and it was with pained surprise that they heard of his death to-day.

He was a devout member of the Catholic church, an honored member of the Knights of Columbus council, and a man among men whose death will cause sorrow throughout the county and beyond its confines, where the name of Dr. Daily was as a household word.

Being interested in farming, a director in the German National Bank, and interested in other business ventures, Dr. Daily was always a ready talker along any lines of business, and it has often

been the writer's pleasure to visit him in his office and to wonder how a man whose every minute seemed used for the service of others could keep so interestingly posted on the business, social and political happenings of the world which he seemed to delight in discussing during his few leisure moments.

After coming to Scottsville, Dr. Daily was, on November 4, 1885, married to Clara E. Lutz, who with eight children, six daughters and two sons, are left to mourn the departure of a kind, loving husband and an indulgent father: The children are: Mrs. Ed. Burgan of Concordia, Mrs. L. E. Rowley of Jewell City, the Misses Mattie, Florence, Alice, Frances and Ruth of this city, John Daily, who is attending Creighton Law school at Omaha, Nebr., and Paul Daily, who is attending college at St. Marys, Kansas. He is further survived by two brothers and two sisters as follows: John Daily of Medford, Oregon, Patrick Daily of Emmet, Idaho, Murt Daily of Beloit, Mrs. A. J. Loomis of Sterling, Colo., and Mrs. Kirby of Long Valley, Idaho, as well as many more relatives.

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REVIEWS.

Treatment of Leg Ulcers.—Lindemann (Deutsche Zeitschrift fur Chirurgie, Bd. 114, Hefte 5 and 6) reports his experience in the treatment of leg ulcers, and says that in case of small ulcers the best treatment is the application of an ointment with bandage after curetting the surface; in moderately bad cases skin transplantation after the method of Thiersch. If there is marked varicosity of the veins they should be removed through a number of small incisions, being careful to protect the skin. Incision of the ulcer or of the entire leg region after the method of Rindfleisch-Friedel is not in any case to be recommended. For the very severe cases of leg ulcer with changes in the bone, amputation is to be seriously considered, for by this means those who have been for a long time totally disabled may be restored at least to partial usefulness. Prophylaxis is very important. The circulation should be kept good in the legs by means of foot baths and massage. Anything which tends to the production of an ulcer must be avoided. Edema and varicosity of the legs must be combated by means of bandages, and the smallest injury must be carefully treated so as to bring about healing as quickly as possible.—Therapeutic Gazette.

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Repair of Perineum.—W. B. Dorsett, St. Louis, (Journal A.

M. A., September 28), holds that too little attention has been paid to the complex anatomic structure of the perineum in the various procedures for its repair. The loss of tissue due to denudation, excision of scar-tissue and the union of unlike tissue are apt to cause haphazard union and loss of proper function. Careful dissection and union of like structures should be the object,and he describes and illustrates by cuts an operation which conforms to his ideas. In it there is no loss of tissue by denudation, the initial incision is only long enough to bring into coapation the levator muscle and the transverse perinel muscles and does not contemplate in any sense the dissection of scar-tissue. He claims the following advantages for this operation: 1. No loss of tissue. 2. No formation of hard scar-tissue. 3. No danger of soiling the wound, as it is unnecessary even to touch with either finger or instrument the interior of vagina or rectum. 4. The rapidity of execution. 5. The union of like structures and not haphazard union of tissues unlike in structure and function. 6. No effort is made even in irregular cicatrices due to irregular tears to remove them, but only to divide them at right angles and to draw together and interpose between their upper and lower segments retracted fascia and muscle. Thus is produced a more natural and better functionating perineum.

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MISCELLANEOUS

When is Advertising not Advertising?—The following from Brooklyn Life, a newspaper published in Brooklyn, shows what newspaper men usually think of a doctor whose name is constantly before the public in connection with professional work:

DID NOT ADVERTISE?

"When the advertising man called on Dr. Smith to get business for the paper which he represented he was told, rather loftily, that it was against "professional ethics," to advertise. But when the cub reporter stopped at the doctor's office two hours later for news items, he received the following:

" 'Dr. H. Johnson Smith is moving his office from 1 Bradley block to 146 Main Street, where he will have an entire suite of rooms. This change was imperative on account of his rapidly increasing practice."

" 'Mrs. Alice Jones of North 10th street fell upon the pavement near her home this morning, sustaining a broken wrist. Dr. H. J. Smith reduced the fracture.'

" 'Dr. H. Johnson Smith has returned from a professional visit to Snyderville.'

" 'Wellesly West, the well-known manufacturer, who has been ill for several weeks, shows marked improvement to-day. His physician, Dr. H. Johnson Smith, believes he will soon be convalescent.' "—Missouri State Medical Journal.

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To the readers ofthe Journal of the Kansas Medical Society:

About six years ago the writer began to use vaccines in the treatment of typhoid fever. Since that time he has thus treated more than one hundred cases and has obtained numerous articles upon the same subject written by physicians in various parts of the world. It seems possible, however, that some may have escaped notice. He also realizes that many of the profession may have treated some cases without reporting them. A paper upon the subject is now in the course of preparation. In this it is earnestly desired to incorporate reports from a large number of cases, good, bad and otherwise. He accordingly makes the following request to the readers of this Journal:

Will any one who has used vaccines in the treatment of typhoid fever, whether but one case or more, kindly communicate to him that fact accompanied by name and address of the reporter. If the results have already been reported, a note of the journal in which they appeared will be sufficient. If they have not been reported, a short blank form will be sent to the physician to be filled out. Due credit will be given in the article to each person making a report. If any physician happens to know of other conferees who have any such cases, it will be appreciated if he sends their names, as they may not happen to read this note. It is hoped that by this means, a sufficient number of cases may be collected to somewhat definitely settle the now mooted question whether vaccines are or are not of benefit in typhoid therapy.

Reports of cases will be accepted at any time in the future but preferably by November or December of the present year.

Kindly communicate with Dr. W. H. Watters, Director of the department of pathology and bacteriology, Evans Institute for Clinical Research, Boston, Mass.

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For Sale.—Static machine, resonator, 500 c. p. leucodescent lamp; victor vibrator, microscope.—Gertrude E. Barnes, Adms. 1273 Clay St., Topeka, Kansas.

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Individual Towels.—Professor Poncet has reported to the Paris Academy of Medicine the possibility of the transmission of tuberculosis by perspiration. In a careful examination of the

perspiration of consumptive patients he claims he has found 42 per cent containing tuberculosis bacilli. Claiming that if a tubercle bacillus can leave by the skin, it may enter in the same manner. he has recommended vigorous skin hygiene. While his results have not yet been corroborated, they are worthy of attention during this hot season of the year when profuse prespiration is so normal. The entire subject of public bathing and common towels is brought forcibly to the front. The sterilization of the water in bathing pools and the abolition of the roller towel in public houses, barrooms and toilets requires consideration.

Of far more importance is the study of the bacteriologist of the Massachusetts State Board of Health, who has recently investigated the bacteria content of roller towels taken from a number of toilet rooms. Twelve towels were studied with a view to ascertaining the presence of any bacteria presumably of fecal origin. Particular attention was given to organisms of the colon type. The bacillus coli communis was isolated from three of the towels, while four others gave marked evidence of fecal contamination. Considering the possibility of infection of towels by typhoid carriers and the consequent infection of the subsequent user of the towel, the possibility of the spread of tuberculosis through this medium must be borne in mind in the event of Professor Poncet's investigation proving to be correct. The decrease of ophthalmic diseases in institutions became most marked through the establishment of individual towels. It is important that with the abolition of the common drinking cup the common roller towel should give way to a more rational and hygienic institution.—Medical Review of Reviews.

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The Psychic Control of the Patient.—The control of one mind over another requires the confidence of the patient in the physician, and the ability of that physician to inspire more confidence in his patient than that patient himself possesses. It is a curious fact of the human mind that those who are weak and are struggling upward are never able to be any better than they think the man who is helping them expects them to be. When once they have gained their self-respect and have regained their former pride and vigor so that they can stand on their own individuality alone, then will they go to any limit of which they are individually capable.—Lambert in Boston Medical Surgical Journal.

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Several hundred patent medicines that are enjoying a wide

sale will have their distribution prohibited or restricted if the Richardson amendment to the pure food and drug act, now being considered by the house committee on interstate and foreign commerce, becomes a law.

"Soothing sirups," diphtheria "cures," headache "remedies" and other panaceas containing cocain, morphin and other dangerous drugs, cancer "cures" alleged to be infallible and consisting of water and alcohol, "fat reducing" creams, made of soap and water and "guaranteed to remove a pound of fat a day," and all other preparations indulging in fabulous and erroneous statements as to their curative powers will not be permitted to be shipped in interstate commerce.—Illinois Medical Journal.

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Under the title of "Two Patent Medicine Statesmen," Collier's Weekly of June 22, publishes a two-page article, with abundant illustrations, proving conclusively the intimate relationship which Champ Clark and William Randolph Hearst bear to the Great American Fraud. Champ Clark's endorsement of Electric Bitters, as published in the daily papers, is reproduced, as also numerous patent medicine and quack doctor advertisements from Hearst's newspapers, the latter to show that Hearts's notice that on and after February 1, he would accept no objectionable medical advertising was not made in good faith.

Concerning Clark's testimonial, Collier's Weekly has this to say: "'The patent medicine testimonial which we present on this page merely shows the intellectual calibre of the speaker (Champ Clark). It is rather an amusing concentration of his quality, and there is absolutely nothing sinister about it. It places him, in other words, intellectually rather than morally."

Concerning Hearst's connection with the Great American Fraud, we find the following: "For years the advertising columns of Mr. Hearst's papers have been literally oozing poison and fraud, very profitably to Mr. Hearst, but ruinously to his readers for whom he professes such paternal solicitude. Adverse criticism, or some other and less obvious motive, inspried him last winter to make a pretense of purging his pages. Four months after the date set for his cleaning up there are to be found represented in his New York newspapers more than forty medical fakes. For here pouring into the Hearst treasury the "rake-off" from their charlatanry are the foul brood of fake consumption cures, lost vitality nostrums, bust developers, venereal quacks (non-local),

medical magic workers, secret eradicators of drink and tobacco habits, harmful kidney, bladder and liver mixtures, absurdly mendacious cure-alls, dangerous rupture appliances, cathartics, reeking with false promises, impossible beauty secrets, a vicious pretense whereby a quack doctor ostensibly giving free medical counsel to the Hearst readers in reality lures them to buy concealed medicines, and such old-time exponents of the Great American Fraud as Lydia E. Pinkham, the Dr. Pierce fakes, Dr. Cooper and Radway's Ready Relief."

Some of this fraudulent advertising is analyzed and the reader informed as to just how vicious and dangerous the claims are as put forth by unscrouplous advertisers who are aided and protected by the Hearst papers.

In conclusion, Collier's Weekly says: "But the plain and painful fact is that Mr. Hearst does not want to clean up. When it comes to the issue it is not the principle that sways Mr. Hearst, it is the profit. So long as medical fraud pays it will hardly be objectionable (so-called) by William Randolph Hearst."—Editorial Journal Indiana State Medical Association.

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CLINICAL NOTES

Laboratory Typhoid Diagnosis..—Blood-culture makes possible an early and positive diagnosis. The typhoid bacilli can be recovered from the blood in a large percentage of cases as early as twenty-four hours after the onset of the illness. This is the most valuable aid in diagnosis during the first week, before the appearance of the Widal reaction. After the first week the percentage of successful blood-cultures take a decided drop. This method of examination, is now even more of a necessity since the use of typhobacterin in the prophylaxis of typhoid fever. A positive Widal results quickly after the vaccination and persists for a varying period, making the agglutination reaction worthless in many cases.—Sledge in Southern Medical Journal.

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X-Ray Diagnosis of Stone in the Right Kidney.—Occasionally in the right kidney area gall-stones have been mistaken for kidney stones, but this error is inexcusable to-day, for it is a simple method where doubt exists to make stereoscopic plates and establish a positive diagnosis. A more simple method consists in making an extra plate with the patient lying on the abdomen, the reverse of

the first position. This second plate will show a shadow of increased dimension if it be a kidney stone a smaller shadow if it be a gall-stone. It is essential to have the patient well prepared, the intestinal tract being thoroughly emptied and the patient put on liquid diet. Before making the exposures the skin should be thoroughly inspected, for deeply pigmented skin growths have been mistaken for stone.—A. C. Heublein, Yale Medical Journal, April, 1912.

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A felon may frequently be aborted by covering the end of the finger with cotton saturated in alcohol and protected from the air by a rubber finger cot.

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When preparing the radial artery for transfusion it is very important to gently dissect out and tie with very fine ligatures the branches of the vessel in the field. If any of these is torn or bruised, a clot will form in it which, by extending into the radial, will interfere with or prevent the flow of blood.—American Journal Surgery.

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The use of tents in the cervical canal has caused death in a few hours from acute spesis. Although the tent may be sterile the cavity of the uterus or cervical canal may contain infectious material.

There are many instances where minor infections have followed the use of tents. As long as it remains in the cervical canal it will prevent the escape of material from the uterus, and if the discharge is being rapidly formed a dangerous amount may accumulate in from one to three days, which is the time that a tent is usually allowed to remain in place.

The cervical canal can be safely dilated by means of graduated dilators or a steel branch dilator. If a woman forty or more years of age has severe uterine hemorrhage in spite of repeated and thorough curettage, and though no malignant disease is found on microscopical examination, hysterectomy should be performed.

Vaginal hysterectomy should not be attempted when, with the patient under an anesthetic, the cervix cannot be drawn down to the external parts and the upper part of the uterus felt from the vagina with the fingers behind and the thumb in font.

Sudden inversion of the uterus following delivery has, in one instance I know of, resulted in fatal postpartum hemorrhage. If this accident is discovered quickly enough, the uterus can usually be replaced. but if the cervix contracts, the inverted body becomes congested and it is impossible to replace it. In such a case, if the hemorrhage can not be controlled by direct pressure, ligatures should be so introduced at each side of the uterus as to compress the arteries. In all probability the uterus will be sacrificed, but better this than the loss of the mother's life.—Ralph Waldo-International Journal Surgery.

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A prostate which is determined per rectum to be of insignificant size should not for this single reason be dismissed as the cause of a middle aged person's urinary troubles. Small prostates often cause more obstructive symptoms than large ones.

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It is accepted at the present time that in the use of salvarsan, the greatest measure of security against recurrences lies in two or three injections repeated at intervals of several weeks. And then do not forget mercury.

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A marked pallor and a beginning puffiness under the eyes during convalescence from scarlet fever, should direct attention to the kidneys. An examination of the urine is called for.—American Journal Dermatology.

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The necessity for early recognition of kidney disease is emphasized by the influence a carefully regulated mode of living, including a well chosen diet, has on prolonging life.

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Tubercle bacilli in the urine denote the importance of immediately prosecuting further investigations of the urinary system.

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A point well to be remembered in the diagnosis of an indurated sore on the penis or within the urethra, when a denial of exposure is received with credence, is the question of malignancy. A small section should be excised for examination.—American Journal Dermatology.

THE JOURNAL
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SINUSITIS.

DR. H. L. ALKIRE, Topeka, Kansas.

Read before the Kansas Medical Society, May 1, 1912.

That condition—superficially diagnosed nasal catarrh, and carelessly treated with sprays, is so common in this region that every practitioner of medicine should be familiar with the anatomy, physiology and such methods for diagnosis as will enable him to determine the location and nature of the pathology in such cases.

Desiring to make the mental picture, which I wish to convey, of the accessory sinuses in health and in disease, as practical as my ability will permit—will briefly review such parts of the anatomy of these cavities of mystery as will serve the purpose.

During the second month of intra-uterine life, the accessory sinuses of the nose make their appearance as small lines or depressions on the external walls of the nasal fossae. These depressions deepen, growing toward the developing bones which they are to occupy. At birth the sinuses are in a very rudimentary state of development, having the appearance of small pouches projecting from the mucous membrane lining the nasal cavities. By the eighth year they have assumed the general characters of the sinuses in the adult. At birth the ethmoidal portion of the nasal space is twice as high as the maxillary portion. Near the eighth year the ethmoidal and maxillary spaces are about equal, this proportion is retained during life. (Chart No. 1 is intended to represent relative proportions at birth. Chart No. 2 is intended to represent the accessary sinuses in the adult.)

The ethmoid cells are quite irregular in number, size and form, they are grouped, according to their point of communication with the nose, into anterior and posterior ethmoid cells. The former open below the middle turbinate, the latter above the middle turbinate.

Chart No. 2 is intended to represent the external lateral wall of a nasal fossa, showing four turbinated bodies, viz., the inferior T., middle T., superior T., and a supreme T., (a turbinate which is as a rule not present). Beneath each turbinate is its corresponding fossa or meatus. The turbinates hide from view the meatuses and the osteae of the accessory sinuses.

Chart No. 2 shows the anterior half of the middle T. removed, exposing the anterior part of the wall of the middle meatus.

Here are to be observed the following objects of special interest, for the part they have in nasal pathology.

The hyatus semilunaris, a grove into which open the osteae of anterior ethmoid cells, near the posterior end the ostea of the maxillary sinus, at the anterior end, in about fifty per cent, the fronto-nasal duct from the frontal sinus, above the hyatus is the bulging wall of an ethmiod cell, this is commonly named the bula ethmoidalis. The lower margin of the hyatus is directed upward and inward, this is the uncinate process. So important is this region about the hyatus semilunaris ,Dr. Ballinger has named it the viscious circle.

The osteae of the posterior ethmoid cells are irregularly situated above the middle T. Chart No. 3 shows the close relation of some of the post-ethmoid cells to the optic nerve; not infrequently these cells extend into the bones forming the roof of the optic foramen and apex of orbital cavity.

Lastly, observe the thinness of the wall separating the orbital cavity from the labyrinth of ethmoid cells.

The charts and the specimen exhibited show in a very satisfactory manner the relation of these cells to neighboring parts.

Permit me to call attention to the relation of the sinuses to each other. The frontal sinus is situated anterior to and above the anterior ethmoid cells and separated from them by very thin cell walls. I believe we will have a more practical idea of the frontal sinus if we consider it as an ethmoid cell extending into the frontal bone. The dried specimen shows a direct communication between the frontal and anterior ethmoid cells. The maxillary sinus is beneath the ethmoid cells, its close relation to them and the thin wall separating it from them should be born in mind. One of the specimens exhibited shows a frontal sinus and an anterior ethmoid cell having a direct communication with the maxillary sinus the same specimen shows an accessory slit like opening into the nose.

The sphenoid sinus is posterior to the ethmoid cells it usually

has two or more subdivisions called cells, it communicates with the nasal fossa at a point above the upper turbinate.

To observe the charts and the specimen will make it unnecessary to say more about it.

I believe if we will remember the ethmoid cells as a cluster or labyrinth of cells, placed below the anterior cranial fossa and between the nasal and orbital fossae and so closely related to the other accessory sinuses as to practically form one great group of cells or sinuses. It may be easier for us to understand their pathology.

The mucus membrane of the sinuses is a continuation of the mucous membrane of the nose, it becomes more attenuated in the cavities, the epithelium is squamous instead of columnar, it has less of glandular and adenoid cells, also less nerve and blood supply.

It is important to remember that the mucous membrane of the nose and the accessory sinuses performs the functions of mucous membrane and periosteum, that the fibrous layer send fibres into the adjacent bone tissue and into the cell walls. The lamina of bone is frequently so thin the two layers of mucous membrane are practically in contact. Much more might be said of the mucous membrane but time will not permit.

ETIOLOGY OF SINUSITIS.

Causes producing inflammation of the sinuses are grouped as exciting and predisposing.

Exciting Causes.—These are the bacteria.

Predisposing Causes.—Whatever tends to lower tissue resistance belong to this group. These are too well known to require much discussion. They may be sub-divided into:

A—Extra-nasal.

B—Nasal.

To the extra nasal such groups belong: age, sex, climate, environment, habits, occupation, physical condition, constitutional disease, etc.

To the intra-nasal group belong: all nasal and naso-pharyngeal conditions interfering with drainage and ventilation. Also nasal pathology and nasal trauma, dental pathology.

Pathology may be added to this group.

It is generally conceded that sinus disease is secondary to nasal disease, the only exception being when dental caries infect the maxillary sinus,about 50% of the maxillary sinusitis cases are of dental origin.

PATHOLOGY.

Based upon clinical data the pathology may be considered as acute and chronic, superficial and deep inflammation.

The mucous membrane of the nose and its accessory sinuses performing the functions of mucous mebrane and periosteum, the superficial inflammations present the usual phenomena of an inflamed mucous membrane, the deep inflammations the changes found in periostitis, when the two strata, the superficial and deep are involved at the same time the process is a muco periostitis.

The local tissue changes may be breifly recited as follows: For an acute inflammation, the surface is dry and red, the submucous tissue infiltrated with serum and leukocytes, capillaries dilated, after a few hours the exudate appears upon the surface, at first thin, later thick; in favorable cases resolution takes place, usually ten to fourteen days, less favorable cases progress to the purulent type.

The ostea may become occluded, producing a closed empyema.

For a chronic inflammation, the changes are best observed according to the stage of development.

1st stage, tissues are relaxed and vessels distended.

2nd stage, cell proliferation and organization.

3rd stage, contraction.

The mucous membrane may present a granular condition, villous on the surface or fungoid excrescences, thickening, ulceration and necrosis of bone.

Complications.—These depend upon which of the neighboring organs are involved, may be the meninges or the eye.

Polypi have been found in all the sinuses, they are most frequent in the ethmoid cells.

Ballenger in his text-book says of inflammation: It is a threefold process; (a) consisting of increased hyperemia, (b) increased nutrition, (c) increased leukocytosis. Of the reaction, nature's effort to repel the infection, quotes Adami as follows. The reaction may be

(A) Adequate,

(B) Inadequate, or

(C) Excessive.

When the reaction is adequate, the infection is destroyed and the normal condition restored.

When inadequate, the purulent stage is developed and great loss of tissue is the result.

When excessive, the hyper-nutrition results in excessive tis-

sue formation, producing a hyperphasia or hypertrophy and later atrophy.

Fibrous tissue proliferation is a common phenomena at the onset of a chronic inflammation.

SYMPTOMS.

The symptoms are subjective and objective.

Subjective Symptoms.—Pain usually referred to by the patient as headache. May or may not be referred to the region producing it in intensity, it may vary from the mildest to the most severe.

In a typical case of acute frontal sinusitis or anterior ethmoidal sinusitis, the pain may be of a neuralgic character, most intense in the supra-orbital region on affected side, usually worse in the morning, frequently throbbing in character, blowing the nose, percussion or pressure usually intensifies it.

In a typical case of acute sphenoidal sinusitis, the pain is usually felt in the occipital region on the side affected.

Sphenoidal inflammations frequently produces frontal and occipital pain. Sphenoidal and ethmoidal inflammation, often produces a vague, deep seated pain in the head. A headache produced by eye-strain, by a middle turbinate pressing against the septum or an inflamed sinus may be so much alike, when described by the patient, as to necessitate a careful search by the physician before a diagnosis can be made.

Tenderness upon Pressure.—Pressure against the floor of the frontal sinus, does increase the pain in cases of acute inflammation in the frontal sinus when drainage is obstructed. Same is true of acute inflammation in the anterior ethmoid if drainage is obstructed.

Redness and Swelling.—These are very rare manifestations. When present shows involvement of the anterior bony wall of the frontal sinus and integument covering it.

Nasal Discharge.—At first thin water, soon thick mucoid and containing leucocytes, later yellow and contains pus, etc. In quantity it may be very free or very scant, not enough to attract attention of either the patient or the physician.

Anosmia.—Loss of smell, is a frequent symptom of ethmoiditis, is usually due to closure of the olfactory slit.

Cacosmia.—Perception of a bad odor, usually due to suppuration.

Disturbance of Equilibrium.—Giddiness and vertigo are frequently present in catarrhal inflammation or suppurative inflamation. It varies in degree and may not be mentioned by the patient.

Ocular Symptoms.—Sneezing produced by looking at the sun.

The watery eyes resulting from a cold in the head are sufficient to demonstrate the association of the nerve and vascular supply of the eye and nose. It is an accepted fact that acute or chronic sinus disease may produce reflex ocular symptoms.

The thin wall separating the two cavities may not be a sufficient barrier against infection entering the orbital cavity. In such cases the symptoms of an orbital cellulitis, as oedema of lids, congestion of conjunctiva, ptosis, restricted movements, exophthalmus, squint, etc.,

Posterior ethmoiditis has been known to produce disturbance of vision, retrobulbar neuritis, and blindness. Doubtless many cases of this nature have passed unobserved.

Chronic Cases.—Those which the laity, and I am sorry to say, many physicians diagnose as nasal catarrh. Doubtless you are so familiar with this class of cases as to need no description, therefore will only mention some of their symptoms. A discharge from the nose or post-nasal dripping, may be profuse or practically none. Sneezing after exposure to dust or cold, may or may not have frequent colds, symptoms of hay fever, etc. Headache or neuralgia is not an infrequent symptom. Deafness is of common occurrence. Many of these patients have tried sprays and all the usual remedies recommended for nasal catarrh. Most of these are cases of chronic ethmoiditis and are amenable to treatment.

Objective Symptoms.—Polypi,attached to or near the middle turbinate are nearly always positive evidence of chronic ethmoiditis.

Middle Turbinate as an Index.—When swollen it is a valuable symptom of ethmoiditis.When hypertrophied, ethmoiditis should be suspected.

Unfortunately, ethmoiditis may occur without abnormalities of the middle turbinate being observed.

The Exudate as a Means of Diagnosis.—An exudate flowing from under the middle turbinate evidently must come from some one of that group of sinuses known as the first series, viz., those communicating with the middle meatus. The character of the inflammation may to some extent, be judged by the character of the exudate.

An exudate in the olfactory slit, probably comes from the post-ethmoid. In all suspected cases careful examination of the following intra-nasal regions, middle turbinal, olfactory and sphenoidal.

If findings are negative and symptoms annoying, irrigate the sinuses and examine the washing of each.

Transillumination frequently gives valuable information.

A skiagraph is of value in some obscure cases.

The probe in trained hands may be of value in locating uncovered bone.

In closing I wish to say I have only endeavored to touch some of the high places for the purpose of stimulating greater interest in that great class of cases, vaguely diagnosed as catarrh.

In the preparation of this essay I am indebted to the following writers for valuable contributions to the literature of Rhinology: W. L. Ballinger, Chicago; D. B. Kyle, Philadelphia; H. J. Hartz, Detroit; H. W. Loeb, St. Louis; J. P. Schaefier, Ithaca; C. R. Holmes, Cincinnati. R. H. Skillern, Philadelphia; C. G. Coakley, New York; Hill Hastings, Los Angeles; F. C. Todd, Minneapolis.

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TYPHOID VACCINE. (PROPHYLACTIC.)

DR. M. D. McCOMAS, Fall River, Kansas.

Read by title before the Kansas Medical Society, May 2, 1912.

SYNOPSIS.

1. Introductory.
2. Typhoid, a definition.
3. Etiology, modes of conveyance.
4. Opsonins and opsonic index, method of determining.
5. Typhoid vaccine, (prophylactic.)

I desire to express to you all, my thanks for the honor of participating in this forty-sixth annual, and my first state medical society meeting.

It is a pleasure to be with you, to realize what the society means to the state; to realize to be one of you is to be placed in a position of gravity and responsibility and with this realization uppermost in my mind, I shall try as best I may to uphold the dignity and responsibility of the profession.

In casting about for a subject, I decided that the prophylactic treatment of typhoid fever would be of much interest to you all.

Typhoid fever is an infectious disease, characterized anatomically by hyperplasia and ulceration of the lymph-follicles of the intestines, swelling of the mesenteric glands and spleen, and parenchymatous changes in other organs. The bacillus of Eberth is constantly present in the lesions. Clinically the disease is marked by fever, a rose-colored eruption, diarrhoea, abdominal tenderness tympanies and enlargement of the spleen, but these symptoms are extremely inconstant and even the fever varies in its character.

Typhoid fever is one of the diseases which leaves behind it a

very considerable protection against subsequent infection. Second attacks occur just as they do in smallpox, but they are not common.

In view of this high ratio of immunity following typhoid, it is not surprising to find that studies looking to the production of artificially conveying immunity were undertaken early in the history of modern bacteriology.

Pasteur's success in immunizing animals against anthrax, led Fraenkel and Simon as early as 1886, to investigate the question of producing artificially an immunity against typhoid.

It was not until after Pfeiffer had shown that the toxins of cholera and typhoid bacilli were not soluble, as in diphtheria toxin, but were integral parts of the bacillary substance, that real progress in immunization against these two diseases became possible. It was not until 1896 that Tfeiffer and Kolle, in Germany, and Sir A. E. Wright in England, reported successful attempts to protect human beings. Their paper to be sure describes only two cases, but it was so comprehensive that it covered the field completely. They showed not only that agglutinins were produced in the blood in response to the inoculation of dead bacteria, but that a bacteriolytic power of the blood was also raised in the same way as it was during an attack of typhoid.

Typhoid fever prevails especially in temperate climates in which it constitutes the most common continued fever. It prevails most in the autumnal months, occurring in the larger per cent of these months, so that it is often reported as autumnal fever. Epidemics are most common when the ground water is low, under which circumstances the springs and water sources drain more thoroughly contaminated foci and are most likely to be highly charged with poison and it may also be as Baumgarten suggests, that in dry seasons the poison is more dessenuinated by the dust.

The bacillus of Eberth is a special micro-organism constantly associated with typhoid. It is a rather thick, short, motile bacillus, with rounded ends, in one of which, particularly in cultures, there can be seen a glistening round body. thought to be a spore. These bacilli are as a rule flogellated.

In regard to the modes of conveyance we have:

(1) By contagion. Typhoid is certainly not a very contagious disease, but the possibility of direct transmission must be acknowledged.

(2) Infection of water is unquestionably the most common mode of conveyance. Many epidemics have been shown to originate in the contamination of a well or spring. Milk may also be the source of infection; filth, bad sewers and cess-pools cannot in themselves cause typhoid, but they furnish fertile soil.

In 1898, Sir A. E. Wright inoculated about 4,000 men of the British Indian Army, and secured very good results, soon after this came the Boer War and Wright furnished vaccine for about 100,000 volunteers. The fact that some of the vaccine used by both the English and the Germans may have overheated and thus weakened, gives the best explanation of the occasional unsatisfactory results which were obtained in the early days of this work.

During the last eighteen months, according to Major Russell's report, dated March 2, 1911, there was vaccinated 12,644 persons and among them there was five cases of typhoid, with no deaths. During the same period there occurred in the remainder of the army 418 cases with 32 deaths. The rate per 1,000 among the vaccinated was 0.2, while in the army at large it was nearly ten times as high. With the memory of Camp Chickamauga still fresh in our minds we are the better able to appreciate the great strides which have been made in preventative medicine since the days of the Spanish war. During the campaign there were 20,738 cases of typhoid with 1,580 deaths, and all within three and a half months, now among the 18,000 men who were mobilized on the southwestern border for over two months, living under the usual camp conditions where rain and mud prevailed, the only case of typhoid which developed, was that of a single teamster, who was unprotected by vaccination.

The opsonic method of treatment is based upon the theory that the blood contains substances known as opsonins, whose function it is to act upon bacteria in such a way as to make them more easily destroyed by the phagocytes. The treatment consists of an injection into the subcutaneous tissue of the patient, of a sterilized emulsion of the bacteria with which the patient is infected. The injection of such an emulsion increases the opsonic power of the patient's blood. This emulsion is called a "vaccine". The opsonic index is the relation between the opsonic power of the patient's blood serum toward the infecting organism and the opsonic power of a normal pressure blood serum towards the same organism. This index is determined by exposing a portion of the culture of the organism to the action of the patient's serum in the presence of a specially prepared polymorphonuclear leukocytes, and a similar portion to the action of a normal person's serum under the same condition, and then counting the bacteria ingested by a definite number of the leukocytes in each proportion. The relation between the two counts is the the "opsonic index", showing the degree of immunity in the individual.

Now let me describe the typhoid vaccine, (prophylactic.)

This is a 24 hour culture of the typhoid bacillus, grown on inclined agar, and suspended in a physiologic salt solution to which has been added a 0.02% solution of trikresol as a preservative. This product is standardized by making a carefully estimated count of the number of bacteria per cubic centimeter of suspension, and the organisms are killed by heating. This is placed upon the market in four different packages: (1) Rubber-stoppered bulbs, made of glass, three in a package, one bulb containing 500,000,000 bacteria sterile and ready for use, and the other two containing one billion each. (2) Rubber-stoppered glass bulbs, thirty in a package, ten containing 500,000,000 bacteria each, and twenty of one billion each. (3) Syringe containers, three in a package, one containing 500,000,000 and the other two one billion each. (4) Single syringe-containers of 2½ billion bacteria, so graduated that the first injection may consist of 500,000,000 bacteria, and the second and third injection of one billion each.

This vaccine is intended primarily to be used for protective inoculations against typhoid. The vaccine is administered subcutaneously, in the usual manner, observing strict asepsis. The skin is scrubbed, at the point of injection, with soap and water, and then rubbed with a 5% solution of phenol, this latter not only disinfecting the area, but serving as a local anaesthetic as well. Shake the bulb well before injecting the dose. Take up into the syringe container the amount to be injected and restopper the bulb at once, expel the air before injecting, and re-sterilize the needle before the second injection.

In regard to the dosage, it is conceded at the present time that three doses are required to establish complete immunity, although very satisfactory results have been obtained from two. Authorities advocate 500,000,000 bacteria as the primary injection, to be followed by a second and a third dose of one billion bacteria at intervals of ten days. A mild reaction usually follows the administration of typhoid vaccine, which consists of slight fever, and a feeling of malaise, headache and other symptoms ordinarily following a mild intoxication. The local reaction consists of a reddened area of skin about the size of the palm of the hand, accompanied by some tenderness. In rare cases the local reaction covers the entire arm but in no case does any ill effect whatever last longer than 48 to 72 hours. The reaction if any, occurs a few hours after the administration of a dose, therefore, it is best given in the late afternoon in order that the headache, malaise, etc., may not appear while the patient is awake.

Persons not in good health should not be inoculated, neither

should women at or near the time of the menstrual period. The presence of fever constitutes an absolute contra-indication, while the indulgence of alcoholic beverages at the time of inoculation, or before full recovery, should be strictly interdicted.

Gosman, of the United States Army Medical Corps states that typhoid vaccine is the most valuable asset which we have in combating an epidemic, and should be used by nurses, ward attendants, hospital corps, physicians, red-cross assistants, medical students and all persons who contemplate a journey into a section where typhoid is known or suspected.

I am glad of the opportunity to be with you, some of whom are my class-mates; some who are school-mates; some of which are my dear professors, while others, physicians and surgeons, with whom I am going to be better acquainted before the meeting is adjourned.

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SOME PATHOLOGICAL CONDITIONS OF THE URETHRA AND THEIR TREATMENT THROUGH THE URETHROSCOPE.

DR. C. S. EVANS, Hutchinson, Kansas.

Read before the Kansas Medical Society, May 2, 1912.

We have both the acute and chronic forms of urethritis. Not all acute forms become chronic but many chronic forms have acute exascerbations from misdirected treatment or injudicious acts on the part of the patient.

We will try to confine our remarks to the conditions in which the urethroscope will be an aid in diagnosis and treatment. For the patients good all instrumentation should be kept free from the acute forms as, without some skill and knowledge many chronic forms may become acute at least for a time and thereby more harm than good will be done.

Follicular, cystic, ulcerative and granular urethritis and tumors are the most satisfactory field for urethroscopic work. We may have a folliculitis, pari-folliculitis or peri-urethral abscesses, one or several glands may be involved and at times can be felt through the floor of the urethra as small nodules; these with deep prostatic involvments, are the source of auto-infection. They

may degenerate into little cysts and the surrounding tissue becomes involved. They are typical around the frenum and farther back they reach down into the corpora cavernosa, and if not diagnosed and treated early, urethral fistula will follow.

The cystic forms are retentian cysts, due to occlusion of the uretheral glands. They may develop from mucous glands but generally from the glands of Cowper.

Ulcerations, includes simple erosions, hard and soft chancre, tubercular ulcers, and degenerated gumma. There are easily located by loss of normal luster of the urethra. Erosions are caused by careless use of instruments or urethral infection, usually gonorrhoeal infection. At first, there is only loss of superficial epithelium, which later becomes an ulcer, if not healed. If it heals the epithelium becomes stratified and there is a thickening of the mucosa, throwing it into folds, preventing or reducing the number of striations; and here we get the stricture of large calibre described by Otis, and from the ulcers we get the strictures of all grades.

The chancres are usually near the meatus, the soft chancre is very red and with somewhat free discharge; the hard chancre may vary in color and the discharge is scanty and serous; its location is surrounded by a hard infiltration. If tubercular ulcers are suspected or known to exist don't use instruments of any kind except for diagnosis of trouble farther up the genito-urinary tract, it is always secondary to infection higher up.

Tumors effecting the urethra are polypi, papilloma and carcinoma.

The polypi are very rare; they are pale, pedunculated little growths. The papilloma are more common and may be found in all parts of the urethera; if they are discovered in the anterior parts the posterior urethra should be examined with the urethroscope, if we expect results in the anterior part. Carcinoma is very rare; it produces a firm incurable stricture

Chronic pathological conditions quite often tries the patient's confidence, and the doctor's ability. Commencing with the posterior urethroscope, introduced into the prostatic urethra. Upon inspection we may see an anemic congested and inflamed condition, marked erosions or granulated areas, bleeding easily to the touch; or a glandular discharge, thus obscuring the field. Next, we see the verumontanum, varying in size from a small grain of wheat, to filling the lumen of the tube, and if it is not too much congested, one can see the ejactulatory ducts on either side and by gently raising the tip of the urethroscope can see the sinus-pocu

laris on the summit of the verumontanum. Fortunately it is the floor of the urethra that is usually involved, thus giving us a much easier working field. We find similiar scarred anemic and congested conditions, in the membranous and bulbous portions. Cowpers glands may become involved and impinge on the membranous portion or be seen discharging from their orifices into the bulbous portions.

The spongy portion may show erosions, granular areas or infected and discharging glands or ducts, in all stages; or may be covered by an exudate, and only visible after removnig it.

Treatment varies in different individuals, as to frequency of treatment and strength of solution used; with proper technic and skill relief can be given that could not be accomplished in any other way.

The first consideration is that we may be able to locate the exact lesion and can see what we are going to treat, and can select or choose our treatment; can watch the results and see if it is reacting too vigorously, or if solution is too weak. We can also make smears for microscopical examination so we will know more positively what we are treating.

In true strictures the urethroscope has neither diagnostic or therapeutic value in comparison with other means we have at our command.

Many patients, both old and young, could find better and a shorter road to health through urethroscopic diagnosis and treatment.

Dr. Max Huhner reports some beautiful results in cases visiting the Mt. Sinai nervous clinic, where nothing of a pathological nature could be located by the neurologist, even by repeated examinations. They were referred to Dr. Huhner and with the urethroscope the pathological lesion was located in the prostatic urethra and under proper treatment they were soon restored to health.

I wish to report a case or two to illustrate the benefit urethroscopic work of interest.

Case 1. Age 22, had gonorrhoea for the first time; 14 months before I saw him; at first he treated himself under the advice of an "experienced friend," but discharge got worse. Urinating, he said, was his continual occupation, when awake; and could not sleep at night for chordee. He then went to a physician who gave him a prescription for an injection. It cured him in a week, he said, no discharge; all was fine. But a little pain in the perineum. A week later he drank some beer and the next day the discharge

returned. He went back to the physician and was again cured and recured several times in the next eight or ten months. About this time intercourse became painful and emissions were followed by a little show of blood and his manhood began to fail him, as he described it.

I examined and found the prostate enlarged but little. I was able to pass a No. 26F olive pointed bougie, with no obstruction going or coming. I next introduced No. 26F posterior urethroscope. No pain until the point entered the prostatic urethra. On inspection I saw a large verumontanum, bleeding at the slightest touch; by the application of styptics the bleeding was checked. After that a local application was made once or twice a week for a few weeks, thus removing all signs and symptoms. And as no gonococci was found, on miscropic examination, he was dismissed and instructed to report in two weeks. I saw him again in six weeks. He was feeling fine and an inspection showed a clean, healthy field and prostate, and seminal vesical stripping showed no gonococci.

Case 2. "F" aged 45; first infection. Microscopical examination showed gonococci; attack being mild, except for four or five days. He lived out of town so I saw him only once each week. It run about the usual course, without complications. About two weeks after this a discharge showed up, and, on examination, you could feel a small induration on the floor of the urethra, about one and one-half inches from the meatus. Discharge kept up for four or five days and stopped, to appear again in about ten days. A few irrigations and it stopped. He was going away for a few weeks and I gave him an injection to use. I was absent for a time, and when I returned, about three months later, I found the discharge as before I left, i. e., intermitting. I now used the endoscope and found a follicular abscess, about the size of a shot, ready to open. Upon opening, it showed gonococci. After a few local applications it healed and he has reported no trouble since. That was about four months ago.

While much harm can be done by abuse of the urethroscope, with proper judgment all sufferers of chronic urethritis can be relieved.

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In removing a foreign body from a joint none but an uncontaminated gloved finger should be permitted in the wound, and that no more than is necessary.—American Journal Surgery.

THE JOURNAL
OF THE
Kansas Medical Society.

JAMES W. MAY, - - - - EDITOR.

ASSOCIATE EDITORS—C. W. REYNOLDS, C. C. GODDARD, HUGH B. CAFFEY, W. E. McVEY, W. E. CURRIE, ARCH D. JONES, W. F. SAWHILL, O. D. WALKER, C. S. KENNEY, E. J. BECKNER, J. A. DILLON, W. F. FEE.

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EDITORIAL

The following editorials from the president and councillors of our society are in response to a letter from the editor requesting an expression upon the political situation in Kansas, regarding the candidates for Governor. That we should take some stand in this matter under the circumstances, there is hardly room for doubt. Political faith should not enter into the discussion whatsoever. We have on the one side a candidate for Governor who has shown by all past performances to be entirely out of harmony with the medical profession of the state. He has cast his lot with the patent medicine vendors, quacks and medical what-nots, and what is worst of all, has attempted to justify his position by defending their acts. Now, if his position is such in these respects, what are we to expect in matters of public health and good medical legislation should he be elected Governor? Why not put a man like "Dr. Carson" (whom Mr. Capper so ably defended), as a member of the Board of Health. Certainly if "Dr. Carson" was so good to cure diseases, he should have been equally so to prevent them, though his "system of practice" would not require quarantine or any precautions to prevent epidemics. Again, where would the legally qualified and reputable medical profession of the state be should he use his influence to annul the benefits of the medical

practice Act? To let the bars down to "Chiropractors," "Magnetic Healers" and their type, would seem to be right in line with his arguments.

On the other hand, Mr. Hodges has given assurance that he will be heartily in favor of all just laws that are for public good and betterment. He will help to elevate the standard of good and wholesome medical laws and that are in the interest of the people of the state and aid in their enforcement. He will not curtail in any way whatsoever the good being accomplished by our State Board of Health, but, rather give it every possible aid in the prevention of disease.

Now is there any choice but to "go to the bat" for Mr. Hodges? It will be the first time in his life your editor will have voted for any but a Republican candidate for Governor, but it will not be the last if the standard of qualifications is not raised.

But neither one vote, nor the vote of the whole medical profession in the state, is enough. If we expect to accomplish anything we must not only vote but work, and use are influence for the interests of the public good. It must be thoroughly understood that there is nothing the medical profession wants, except just medical laws that will protect the public from charlatans, quacks and incompetents who prey upon the ignorant and uninitiated, and laws which will prevent the spread of disease thereby, giving protection to those who cannot protect themselves.

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October 21, 1912.

Dr. J. W. May, Editor Kansas Medical Journal,
Dear Doctor:—

Complying with your request that I, as President of the Kansas State Medical Society, give you my views as to the desirability of the two candidates now before before the people for Governor of the State will say, "By their works you shall know them."

What has there been in the past conduct of Arthur Capper, especially in his attitude toward the physicians of this State to inspire confidence in him or admiration for his attitude toward the medical profession of this state. A man occupying the position of editor of a large daily newspaper, will, if he has the inclination, help the medical profession in many ways, that would be to the interest of the people residing in the state, as well as the profession itself.

On the contrary, the attitude of Mr. Capper during the past, has not been fair to the medical profession and has been a daily insult to every regular physician of this state, in publishing for pay, advertisements of fake remedies and preventatives.

He is now before the people as the Republican candidate for Governor ,(another fraud), and according to his own statement, helped to prevent the nomination of a Progressive ticket in this State, simply for the reason that his chances for election to the high office of Governor would be lessened if he was compelled to make the race against a true Progressive. Theodore Roosevelt, the greatest Progressive and real leader, does not sanction the Capper methods in politics nor the Capper methods in Journalism. The physicians of the state are Progressives and as a rule support the man whom they regard as best fitted to fill the place. Now, if the medical profession could forget or forgive all of Mr. Capper's insults of the past. Yet, if they compare the records of the two men as to their probable fitness for the place, I think the verdict must be given to Mr. Hodges; while Mr. Hodges is of a different political faith than I, yet I have no hesitation in saying that I shall vote for him and do what I can for his election, because I regard him as by far the better man for the place, and one who is broad minded enough to give this State a clean, fearless administration in the interest of and for the people. We of the medical profession are especially interested in the health of our people and especially interested in the prevention of disease among the inhabitants of the state, and what is accomplished along these lines depends very largely upon the attitude of the Governor, and I just have not the faith in Mr. Capper.

Yours very truly,

GEO. M. GRAY, M. D.

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In a few days the people of Kansas will vote to select a chief executive. Will they vote for the man on account of the splendid promises he makes, or will they base their selection on the past history of the candidate? While I have Progressive or, "Bull Moose" inclination, I cannot vote for Mr. Capper for Governor, because I do not believe he is sincere in his declarations. Collier's in an editorial under date of Otcober 12th, calls attention to Mr. Capper's methods of getting money by full page advertisements for the "King of Fakes," swamp root, rheumatic, consumptive and all kinds of fake cures. A man who will sell his advertiseing space to all such frauds, to assist them in beating the good people of Kansas out of their money, is not entitled to be Governor of our great state.

C. W. REYNOLDS, Councillor First District.

For several years the Topeka Capital, Mr. Capper's paper, carried large advertisements extolling a noted quack and his methods as a "cure-all" for all the "Ills that human flesh is heir to."

Some three years since some of the medical societies appointed committees to correspond with Mr. Capper and request him to refuse carrying the same in his paper, as the said advertisement was a detriment to the people of the state physically and financially. The only answer they received was that the matter had been referred to several, so-called theosophists, scientists, chiropractors, etal; and they had advised the retention of the 'AD' and therefore he would be compelled to refuse the requests of the different medical societies no matter how much he would, personally, like to please them in the matter.

Nearly every medical society of the state has since passed resolutions condemning the action of Mr. Capper and the course of the Capital, and in many instances pledging the members to withdraw their subscription to the paper.

When Mr. Capper came out as a candidate for Governor, he was inclined to smooth matters over with the medical profession and agreed to withdraw the obnoxious matter at end of the year if that would make things right with the doctors; I wonder if the death of Carson had anything to do with his desire to be good?

The doctors of the western part of the state would not quit but fought his candidacy. This all being true what can the doctors of the state expect should Mr. Capper, by some unforseen chance be elected?

Would he not use his influence to wipe the Medical Act from off the Statue book?

Would not his particular ilk, the scientist, theosopist, chiropractors and medical freedom thoughtists' take control of affairs and run things generally?

Where would the regular physicians, homoeopathists and osteopaths come in then?

If the doctors of the state care anything for their profession the least they can do is to get out amongst their people and fight as they have never fought before; because, their very existence may be threatened as physicians; not only that, but should he, if elected, see fit to retaliate, the health of the whole state might be endangered, all sorts of communicable disease allowed full sway in the state and Death garner lives as never before in all his reign.

Let us wake up and be doing, get out and work for a man that at least, will not have any temptation to knock out the medical profession of the state, and the laws governing its' practice.

This is no time for politics, let us all work for our own salvation, and elect men that we can hope to get justice from; we cannot expect any from Capper, judging from what he has as a newspaper man, already done; and the trend he has shown in the past, as well as the danger from the advice he said he allowed to influence him in his former decision.

C. C. GODDARD, Councillor Second District.

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Assuming that every member of the state society is acquainted with the character of fake medical advertising which has been carried by the Topeka Capital, and taking it for granted too, that they are familiar with the circumstances relating to the reception which the owner of this paper, (now a candidate for governor), gave a committee from the state society, sent to ask him to discontinue the notorious Carson advertisements, we feel sure that every member, regardless of party affiliations, will agree that the Journal, the official mouthpiece of the society should give some expression of the sentiment which exists amongst the regular physicians of the state, relative to the political situation in Kansas and more especially as pertains to the gubernatorial race.

A crisis is staring us in the face of which we have been duly warned, by those in position to know whereof they speak, and men, are we to stand aside and offer no resistance to the placing of a man in the governor's seat, who has continuously, openly and defiantly disregarded the sacred rights of the physicians of this state? What can we expect in the interest of public health? What will we get in the legislature?

We have men in the House and Senate who are favorable to just medical laws; they proved themselves to be our friends in the last session. Some of them were doctors. But they tell us the fight was fierce, the resistance was almost impossible to overcome and they are afraid of another such experience.

We do hope that intelligent and conservative men will not allow party affiliations to rule their better judgment and force them to support an unfit man for the highest office in the gift of the state.

HUGH B. CAFFEY, Councillor Third District.

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Editor of the Journal:

The physicians of the the state will soon be called upon to

vote for a Governor of our fair state, graft has shown its head in many a place and we need a man who look out for the interests of the people of the state and not for his own financial welfare. We, as physicians, do not believe that a man who will fill his papers with advertisements of frauds in the way of medical humbugs, fakirs, whirling sprays, etc., for the large financial returns that accompany them will make a governor who will carry out our ideas of decent government

This associate editor has voted for the Republican Governor for twenty years, but when the time comes to cast a vote for Mr. Capper my "name will not be written there."

W. E. CURRIE, Councillor Fifth District.

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There is no question before the public to-day that is of more vital interest to everybody than the matter of health and the factors and conditions that contribute to it. And there is no other man in the State of Kansas so well situated to wield an influence for or against the promotion of this cause as the Governor.

This is a matter that should be considered by every intelligent man when he casts his vote next November. The position of one of the candidates for Governor, Mr. Arthur Capper, is well-known to the medical profession at least. He is hostile to a demand that the public be protected from impostures in the practice of medicine; the columns of his various publications are used to boost the business of the rankest kind of quacks and charlatans. Nor does he stop there; under a personal guaranty of the reliability of every advertiser in his papers, he publishes advertisements most vicious and immoral.

If his papers have not been excluded from the mails it is simply because the attention of the postal authorities has not been directed to the offending items.

Is a man who, for the money there is in it, sends his papers into the homes, where pure minded boys and girls may read these nameless and debauching ads, a man to select for a leader of the public welfare.

W. F. SAWHILL, Councillor, Seventh District.

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MR. CAPPER.

Last spring when Mr. Capper announced himself as a candidate for Governor on a Progressive platform, subject to the Republican primary, I did not feel friendly to him for one reason only, and that was the quack medical advertisements found in his publications. I was therefore very much pleased when our worthy

state secretary agreed to stand for the nomination. From my view-point Dr. Huffman would have made an ideal Governor. After his withdrawal, I found upon my primary ticket two men as candidates and Mr. Capper was my choice, and for him I voted.

I grant that the same objections obtain against Mr. Capper now as before the primary.

He has shown a lack of discrimination, when he permits one of the most momental forms of graft in the quack medical advertisements to fill his publications and at the same time declares in his own expressed platform that he is against all graft.

But there are a number of other issues at stake in this campaign and I find in the main that I can agree with and heartily endorse Mr. Capper's views.

I think it would be most unfortunate therefore, if the medical profession throughout the state should so magnify this one objection to Mr. Capper as to blind our eyes to his many good qualities.

I do not believe for one minute that if Mr. Capper is elected Governor that he will make war upon the medical profession of the state, but rather as a fair-minded man, he will do what he can to advance the work of the State Board of Health and other public works of the profession.

Therefore, in picking a candidate for Governor, I shall choose the one who most nearly stands for the things I believe right and of the men before the people of Kansas for this office, my choice is Mr. Capper.

O. D. WALKER, Councillor Eighth District.

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Dr. J. W. May, Kansas City, Kansas:

It offers me personally, a great deal of pleasure to respond to your request asking an expression from each of the councillors of the state society regarding the candidacy of Arthur Capper.

The old saw 'its a long road that has no turn' was never better illustrated than at the present time.

When Mr. Capper was issuing his defi to the 2600 medical practitioners of Kansas a few years ago, his gubernatorial bee was still in the grub stage. At that time his love for the almighty dollar was so strong as to stifle all conscientious scruples he may have possessed and his papers reeked with advertisements that no other publication in the west would accept, we grinned and took the slap but failed to turn the other cheek when the Carson episode came up.

Now its our turn and if the regular, legitimate practitioners of Kansas fail to rebuke methods of this kind by repudiating Mr. Cap-

per, they deserve the excrementitious material that has been heaped on and rubbed in during the past few years.

In this district I believe we have all lost sight of political affiliations and are going to attempt to vote so as not to precipitate any change that might interfere with Mr. Capper's present Journalistic duties.

J. A. DILLON, Councillor Eleventh District.

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CONTRACT PRACTICE AND ITS RELATION TO THE LOCAL RAILWAY SURGEON.

Of all the branches of surgery, that encountered in railroad practice makes the heaviest demands on the qualities of fitness, judgment and conservatism on the part of the surgeon.

The contributing factors to this condition are the frequency of crushing and mangling injuries demanding in their treatment, the greatest judgment and conservatism both in the interest of the patient and the corporation employing him. Not only must the vitality of every scrap of tissue be carefully determined and conserved, often at the expense of a long and tedious convalescence through which the surgeons reputation frequently suffers, but the employer must be protected from the machinations of the ambulance chaser and the patient from the well meant though pernicious advice of family and friends whose sympathies for his misfortune frequently distort their sense of fairness and justice.

The medical legal aspects of railroad surgery are in themselves a source of continual worry to the surgeon for like the "tall oaks" that spring from the little acorn, a portentious railway damage case frequently develops from a negligible injury.

From the very nature of the extent and seriousness of these injuries they demand a skill and ability out of all proportion to the fees received under the contract system of many railroads.

In every railroad town, there is always some doctor who, for the sake of local prestige (and a pass which he rarely has time to use) is willing to saddle himself with the cares and responsibility of local surgeon on a fee basis of 25% or 50% of what he charges his private patients for the same service. In his private practice he has but two interests to conserve, i. e., those of his patient and his own. In railroad practice a third factor enters, in that the legitimate interests of the company employing him must be protected to the best of his ability from the ambulance chaser, the malingerer and the chronic litigant.

For the professional service he renders the employee, he receives one-fourth to one-half the fee he would receive from the

same patient for the same service in private practice. For his clerical service in sending in long detailed reports and the endless (often needless) correspondence and for his diplomatic service to the company, he receives nothing.

Considering his service and value to the railroad company employing him he is the most poorly paid man on the pay roll. The commonest laborer in their employ may ask for and receive more favors at their hands than the surgeon.

In recent years we have read much of the evils of contract practice and of its demoralizing influence upon the profession, yet, I have never encountered anything dealing with contract practice relative to the railroad surgeon. Why? Because contract practice among mine, mill, smelter and other industrial workers must, if tolerated, determine a steady and marked deterioration in the standard and efficiency of medical practice, and is at the same time, an abridgment of the individual right of the industrial worker to employ whoever he may choose to attend himself or family in case of illness or injury.

This was a direct blow not only to the professional, but to the financial interests of the profession at large, and they were neither slow nor timid in voicing their disapproval of such methods and pointing out their evil tendencies.

The physician who, prompted by the thought that his appointment as local surgeon will increase his local prestige, seeks or accepts such an appointment under a contract system based on a schedule far below the standard fee for his service, either does not realize, or fails to respect the fact, that he is in a measure, violating the ethics of his profession. Having secured his appointment he is without recourse as he has voluntarily subscribed to a certain fixed (by the corporation), fee bill, and if he is dissatisfied, he is given to understand that there are plenty on the waiting list for his place.

If the profession is opposed to contract practice let this opposition extend to all forms of contract practice that tend to minimize the value of the doctors service.

Any fraternal or industrial organization, any private individual, has the same right to dictate the value of the doctor's service as a railway corporation, and every corporation should pay the same fee for the same service to its employee that the employee would pay the physician as a priviate patient. Personally, I can see no reason why a railway corporation should pay less than a private citizen for the same service nor why other industrial or fraternal organizations should be so loudly condemned for at-

tempting to arbitrarily fix the value of the doctor's service, while the same fault on the part of the railroad is passed over without comment.

The doctor himself can, in most instances, ill afford to make this concession to "predatory wealth", and why should he?

To successfully combat the evil of contract practice the effort must be consistent and directed toward stamping out the evil in all its ramifications.

The railroad surgeon needs and is entitled to the staunch support of the entire medical profession in securing recognition and adequate compensation for his services.

F. A. CARMICHAEL.

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"ET FU, BRUTE!"

The apparent amicable relations between the druggist and the doctor are seriously threatened. If we are to put faith in the public utterances of the president of the Kansas Pharmaceutical Association, peace negotiation are due to begin "pronto", else the dispensing doctor will run amuck in the next legislature.

The mephitic odors of the bouquet which this gentleman throws to the medical profession suggest a long period of fermentation. We do not know just how it sounded but it reads as follows:

> Another party along the same line that merits condemnation is the dispensing doctor. No matter whether he is a brilliant man or an ignoramus, there is no excuse for his wares being denied inspection under the pure food and drugs act. This individual is law unto himself and he claims the right to dispense any preparation he has in stock regardless of its strength and purity. His back office may be, and generally is, woefully unsanitary. Here the microbe may rest in peace, the dust of ages settles on the pills, the liquids deteriorate, until they have no strength or become too strong; and yet this individual denies the right of God or man to interfere with his dispensing any kind of remedies he may wish to dispose of simply for the cold cash he desires to make. He measures his success from a financial point of view, and works a hardship on the pharmacist as well as the public in general by substituting preparations on hand instead of prescribing standard drugs and medicines kept in stock by the druggist, who stands as a safeguard between his wares and the public and to whom he is amenable under the strictest of laws. There are some exceptions in this class of doctors who claim they have to dispense to protect their business, and if this is true, then they should pass the examinations of the Board of Pharmacy, becoming dispensing pharmacists, in compliance with the law.

Still further evidence of the great respect which the druggists, in general, have for the intelligence, skill and integrity of the medical profession was given in an address by a certain Mr. Englehard of Chicago, whom we are assured by Professor Sayre, of the University of Kansas, is a very great man (pharmaceutically speaking,) for "he says what he feels and feels what he says". We are sure no disparagement was intended in the rather equivocal com-

pliment he paid him in his introduction, the report of which reads as follows: "I am particularly rejoiced to know that we have with us today one who stands head and shoulders above any other editor or publisher in the United States who supports the idea that the pharmacist should be the legal dispenser and he is the only one who took up this matter."

Being assured of the high standing of Mr. Englehard among pharmacists we will quote a few extracts from his address.:

"There is one evil that has been undermining pharmacy and the drug trade until both the profession and trade are in danger of extinction. The evil has been going apace with especially rapid strides during the past decade with the result that the practice of pharmacy in many communities is either wholly a lost art or is represented by a few unhappy relics. I refer, of course, to the dispensing of medicine by physicians. By what right does the physician undertake this function? By the right of skill which is the only recognized right in the State of Kansas and of all other states. He makes no pretense to the right of skill because he well knows that he does not possess the education and training requisite for the functions of pharmacy. It is by the right of omniscience which presumes that the license of the physician is the legitimate gateway to every perogative; the right to practice surgery, refraction and dentistry; to be deemed supreme in the province of sanitation and of hygiene and public health in general. Has not the physician of today, I ask, enough to do to master the complex problem and even mysteries of the healing art that his forces and energies should be dispensed in other directions? Is the medical mind of such limitless compass that it may assume prerogative simply by right of divine commission?"

"But what shall be said of a practice which is causing not only the temple of pharmacy to totter and fall, but which is also undermining to its very foundation, the practice of medicine? Did physicians possess the skill, the knowledge, the superhuman carefulness and freedom from error; were they possessed of more infallibility and their souls wholly free from the thought of personal pecuniary gain, it might then be said that they could safely be entrusted with the right not only to prescribe, but to dispense medicines; but will it be said that there is a divine quality about the medical mind which should be invested with recognition of exceptional rights to their relation to the people? The right to dispense on the plea of skill. Will it be said that the physician has the skill to justify this supreme assumption."

"If, then, the right to dispense be not based on skill, or demonstrated qualifications, can it be defended on the ground of superior service to the people? Are not the number and variety of his errors in prescribing sufficient that he should invite the additional errors inevitably associated with dispensing? Do physicians not make enough mistakes now in writing prescriptions which druggists are called upon to correct, thus becoming the saviors of health and life? That their mistakes are multiplied in dispensing; that there are errors due to carelessness or errors to which men surrounded by the frequent distressing influences of the sick room are especially prone, are facts in the every day experience of the medical men.

Is it not well, therefore, that a third party be constituted under the law to intervene with the skill and training born of specialized study both to detect errors and to insure the greatest possible remedial efficiency."

"Two-thirds of the medicines dispensed in some states and I am told nine-tenths of all the medicine dispensed in Michigan never sees the interior of a pharmacy or passes through the hands of a skilled pharmacist where they would be subject to personal competent dispensing and also to a pure drug law holding the pharmacist to strict accountability."

"Will the druggists of the country stand idly by while their territory is being invaded and devastated, their practice destroyed; their shops bro-

ken up; their prescription counters thrown into the scrap heap; will they permit this without a word of protest? Is it not time that they spoke, if not for themselves, at least for the people, who, after all, are the greatest sufferers? The two great National organizations of druggists have been appealed to for years, but they have remained silent. And why are they dumb? Is it because they dare not speak? Is it because they fear the vengeance of the medical fraternity? Of what earthly benefit is a propaganda designed to encourage the prescribing of official preparations by physicians to be dispensed by druggists in the face of the fact that drug store dispensing is in process of annihilation and as before stated in many communities, a lost art?"

"And now what is the remedy? Shall legislation against this grievous wrong be one of regulation or of prohibition? Prohibition under the conditions which prevail in this country at present would indeed be attended with so many exemptions as to make its enforcement a most complicated, if not an impossible task. To provide for exemptions and exceptions as to make its enforcement a most complicated if not impossible task. To provide for exemptions in favor of the homeopathic physician, (as the devotees of that medical system would demand with a great show of reason) would provoke the cry of unjust discrimination and to attempt the arbitrary reversal of a practice so universal as medical dispensing has become in this country at the present time, would be met with strenous opposition from the large element of the unthinking people who are disposed to insist that the doctor supply his own medicine as a matter of economy.

As a preliminary or preparatory step, therefore, the demand for reform might be for legislation that would not directly prohibit medicial dispensing, but that would compel the dispensing physician at all times to write a prescription and hand it to the patient as an evidence of what he intended to do, or of the remedy he intended to furnish." (Applause.)

We regret that lack of space does not permit us to reproduce the complete address but we feel that these few extracts will enable you to get the drift of his meaning, It was heartily received as is indicated by the frequent applause, and it touched real sentiment as may be seen in the prayerfully pathetic endorsement of Professor Sayre, of the University of Kansas:

By Prof. Sayre: On behalf of this association I want to say that if I had gotten on my knees and asked God to help me say something that was nearest to my heart, I do not think that I could have had a better answer to my prayer than the address which has just been made, and on behalf of the Association, Mr. President, I ask for a rising vote. (Unanimous.)

Lest some one may think the remarks of the two gentlemen quoted do not express the sentiment of the members of the Association we will give you the resolutions that were unanimously adopted. They are as follows:

RESOLUTION.

"WHEREAS, The necessity in the public interest of regulating the dispensing of medicines by physicians is so evident as to demand specific action by an appeal to pharmacists and physicians and the legislature for the enactment of requisite legislation, and

WHEREAS, The profession of medicine and of pharmacy are on record through their representaitve organizations to uphold the spirit and purpose of the pure food and drugs law of the nation and of the respective states, therefore be it

RESOLVED, That we endorse in substance the following as the draft of a bill to be submitted for enactment.

Be it enacted, etc.

Section 1. That any physician who shall sell, compound or dispense, administer, or give away, any medicine or remedy for or to any patient or other person, shall write a prescription or order for such medicine or remedy in such form as to be legally intelligible.

Section 2. The original of any and all such prescriptions, written in every instance of such dispensing shall at the time thereof, be supplied to such person or patient or any legal representative.

Section 3. Any neglect or failure to write such prescription or to furnish a copy as herein provided, shall subject the offender to a fine of not less than Fifty Dollars for each and every such offense.

Section 4. All acts or parts of acts in conflict with this act are hereby repealed.

The complaint of the pharmacists seems to be that the growing custom among physicians of supplying their patients with medicines threatens the business of the local druggist. Therefore, "Is it not time that they spoke, if not for themselves, at least for the people, who, after all are the greatest sufferers?" But the people seem to like the system, for, as Mr. Englehard says in his address: "Two-thirds of the medicines dispensed in some states and I am told nine-tenths of all the medicine dispensed in Michigan never sees the interior of a pharmacy or passes through the hands of a skilled pharmacist" Is it not strange how popular becomes these customs by which the people are made to suffer so greatly.?

We do not deny that office dispensing has become quite popular with physicians in many localities in Kansas and we are willing to accept the assertions of the pharmacists that it is detrimental to their business. But who is responsible for the custom and what have been the conditions which have influenced the physician in adopting it and adhering to it? The pharmacist has himself been responsible for the custom and also for the conditions which have made office dispensing practically a necessity in many localities.

The persistent disregard of the physicians request not to refill his prescriptions has led many to furnish their own medicines. The repeated refilling of a prescription for the person to whom it was originally given is bad enough, but when it is repeatedly refilled for a dozen of his friends and acquaintances it is too bad.

We have known cases where the physician had prescribed an opiate for temporary use, but the pharmacist continued to refill the prescription, without the knowledge or consent of the physician, until the patient became sadly addicted to the use of opium. The writer was once told by a local pharmacist that he had that day refilled a certain physician's prescription for seven different people, none of whom had been the original recipient of the prescription.

Substitution of something that the pharmacist thought would do just as well, or was more conveniently supplied, for the drug prescribed has caused many physicians much disappointment and sometimes serious trouble. When a prescription is once given, the physician cannot control it's destination. If he indicates a certain pharmacist he is immediately suspected of receiving a commission. Substitution was not an imaginary evil and unfortunately is occasionally complained of to-day.

Incompetent and careless compounding of prescriptions may also be mentioned as one of the things which physicians have had to complain of. It is not often even now, that we get two fillings of a prescription that look, taste and smell exactly alike, and sometimes the difference is so marked that we cannot blame our patients for believing that the wrong medicine has been given them.

The thing which has been most bitterly complained of, however, involves a question of moral right and legal privilege. The pharmacist accuses the physician of assuming the right to compound medicines, for which he is unqualified, but he himself assumes the right to prescribe for any sort of an ailment from chilblain to meningitis. A physician cannot now secure a license to practice medicine in Kansas until he has had at least four years in a good medical college. During this four years of medical study he acquires more knowledge of chemistry, pharmacy and materia medica than is ever known by the average pharmacist in this state. No college instruction is required of an applicant to practice pharmacy. But even if he be a graduate of pharmacy he has received no instruction such as is required for the practice of medicine. He does not hesitate on that account, but diagnoses the case, prescribes and fills the prescription, just as he says the physician does. A physician recently reported a case of chancroid which had been treated by a druggist until the under surface of the penis had been denuded and a large section of the scrotum destroyed. Another physician reported a case that had been treated for sometime by a druggist who had made a clinical test of the urine and assured the man that he had no disease of the kidney. Another physician went into a drug store for something and found the clerk prescribing for a patient with "stomach trouble", and the proprietor removing a wart from a ladies hand.

We have mentioned these conditions as influencing the physician to furnish his own medicine but the pharmacist has in another way been responsible for the custom. The manufacturing pharmacist has made office dispensing very convenient and vary satisfactory to the physician. In fact the manufacturing pher-

macist has practically put the prescription pharmacist of a few years ago in the discard, by supplying drug combinations of all kinds, in pills, tablets or in pleasant tasted liquid preparations that are far more superior and more definite in compound than the capsules or quickly prepared combinations of the drug-store pharmacist. That these tablets and compounds are reliable, our friends the pharmacists must admit for they carry them in stock. The assertion that the dispensing physician must depend upon unreliable houses for his supplies is unfounded for he can purchase them from the same manufacturing pharmacists that supply the druggist with his stock.

W. E. McVEY.

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SOCIETY NOTES.

5th District, W. E. Currie, councillor, Sterling:

Program of the Harvey County Medical Society for November:

"DISLOCATIONS."

"Dislocations of the Shoulder," Dr. R. S. Haury. Discussion, Dr. Countryman.

"Pathology and Complications of Recent and old Unreduced Dislocations," Dr. J. L. Grove. Discussion, Dr. O. W. Roff.

"Dislocations complicated by Fractures," Dr. G. D. Bennett, Discussion, Dr. J. W. Graybill.

E. L. ABBEY, Sec'y.

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The Butler County Medical Society held a meeting at El Dorado, October 17th. The following program was given:

Paper—Dr. F. D. Stinson, Douglass, Kansas.

Paper—"Adenoids", Dr. E. S. McIntosh, Burns, Kansas.

Discussion led by Dr. N. E. Wilson, Douglass, Kansas.

Paper—Professional Honesty, Dr. C. M. Mutz, El Dorado, Kansas.

Discussion led by Dr. D. C. Stahlman, Potwin, Kansas.

Paper—"County Medical Society, The Duties of Physicians to the Society and the Benefits Derived From Membership Therein," by Dr. J. R. McCluggage, Augusta, Kansas.

Discussion led by Dr. J. B. Carlile, El Dorado, Kansas,.

J. R. McCLUGGAGE, Sec'y.

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6th District, Arch D. Jones, councillor, Wichita:

The Cowley county medical society met in Arkansas, City, Kansas, Sept. 27-1912, with the druggists of the county as guests.

There was a full attendance, both of members of the society and druggists.

Dr. E. F. Day of Arkansas City, read a paper entitled, "The Relation of the Doctor to the Druggist." His paper dealt mainly with the advertising of remedies for such diseases as tuberculosis, diabetes, etc., by manufacturers in newspapers, over the name of the local druggist, thereby holding out false hope to the sufferers, until too far gone to be benefited by proper climatic, dietetic or hygienic treatment. Dr. Day's paper was very much discussed by the doctors and druggists.

Dr. O. B. Wyant of Winfield, read a paper on "Osteomyelitis."

"Puerperal Eclampsia" was the title of a paper by Dr. J. E. Brock of Arkansas City, and "Thrombo-phlebitis as a Surgical Complication," was given by Dr. H. L. Snyder of Winfield.

The society adjourned to meet at Arkansas City, Nov. 14, 1912, when the annual banquet will be given.

C. R. SPAIN, Sec'y.
Arkansas City, Kansas.

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8th District, O. D. Walker, councillor, Salina:

The Saline county medical society met October 10th in regular meeting at the office of the secretary.

Paper—Symptoms of Duodenal Ulcer, Dr. J. H. Winterbotham.

Paper—Life Insurance Examinations, Dr. O. R. Brittain.

Both papers were freely discussed.

Members present: Doctors W. H. Winterbotham, Neptune, Anderson, Seitz, W. S. Harvey, Lutz, Brittain, J. H. Winterbotham, Simpson, Nordstrom, Moses, Mowery, Walker.

O. D. WALKER, Sec'y.

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The annual meeting of the Medical Association of the Southwest was held at Hot Springs, Ark., October 8-10. The meeting was not as largely attended as previous ones, owing to the poor railroad facilities. The papers on the whole were of high scientific value and the meeting was a successful one in this particular. The entertainments provided by the physicians of Hot Srpings, were elaborate, consisting of a reception and ball, smoker for the physicians and theatre party, receptions and automobile rides for the ladies. Kansas City, Mo., was selected as the meeting place for 1913. The following officers were elected:

President, Dr. W. T. Wootton, Hot Springs, Ark; Vice-Presidents, Dr. W. B. Dorsett, St. Louis, Mo; Dr. E. H. Carey, Dallas,

Texas; Dr. J. H. Barnes, Enid, Okla; Dr. C. C. Nesselrode, Kansas City, Kansas; secretary-treasurer, Dr. F. H. Clark, El Reno, Okla.

Committee on Ethical Practice.—Dr. Jabez N. Jackson, Dr. Howard Hill, Dr. Wm. Fisk, Dr. C. C. Conover, and Dr. F. W. Froehling.

Section on Medicine.—Chairman, Dr. F. C. Neff, Kansas City, Mo; vice-chairman, Dr. Geo. A. Boyle, Enid, Okla; secretary, Dr. C. C. Conover, Kansas City, Mo.

Surgical Section.—Chairman, Dr. J. F. Binnie, Kansas City, Mo; vice-chairman, Dr. W. B. Dorsett, St. Louis, Mo; secretary, Dr. D. A. Myers, Lawton, Oklahoma.

Section on Eye, Ear, Nose and Throat.—Chairman, Dr. J. E. Sawtell, Kansas City, Kansas; vice-chairman, Dr. J. H. Barnes, Enid, Okla; secretary, Dr. J. F. Rowland, Hot Springs, Arkansas.

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NEWS NOTES

Personal.—Dr. A. H. Fabrique was given a banquet in honor of his seventy-seventh birthday anniversary at the Wichita Club, September 9.

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Dr. H. W. Horn of Wichita, has been appointed chief surgeon of the Kansas City Mexico & Orient Railway.

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Dr. George R. Little of Wichita has been appointed city physician vice Dr. Lloyd P. Warren resigned. Dr. Warren has departed for Europe for an extended tour.

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Dr. W. J. Murphy has resigned as Surgeon of the Soldiers Home at Leavenworth.

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Dr. A. D. Farnsworth, who has been in Arkansas City, for the past two years, has located in Drexel, Mo., where he will practice.

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Dr. John G. Gage, formerly of New Orleans, La., has recently located in Arkansas City, Kansas.

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Dr. F. E. Goither of Lenora, has purchased one of the drug stores of that city.

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Dr. Clyde Leigh Appleby and Miss Edna Frances Bragunier of Peabody, were married October 17.

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At the annual meeting of the association of Santa Fe sur-

geons, held at Albuquerque, New Mexico, Oct. 4-6, Dr. M. L. Bishoff of Topeka, was re-elected secretary.

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Dr. H. P. Knowles has recently moved from Huntsville to Sterling.

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The Advisory Commission appointed to select a site for the State Sanatorium for Tuberculosis, has reported its approval of a tract of 240 acres, two and one-half miles west of Newton. The last legislature appropriated $50,000 for the sanatorium.

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OBITUARY.

Frank H. White, M. D., Kansas Medical College, Topeka' 1905; died at his home in Effingham, Kans., September 23, from acute dilatation of the heart, aged 37.

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Christian N. Bishoff, M. D., Eclectic Medical College of Pennsylvania, Philadelphia, 1871; for two years a member of the Kansas State Legislature; for thirty-five pears a practitioner of Eudora Township, Douglas County, Kans; died at his home near Eudora, September 22, aged 74.

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SAMUEL CHARLES EMLEY, A. M. M. D.

Dr. Samuel Charles Emley, a member of the Kansas Medical Society, a member of the American Medical Association and an Associate Professor of Diseases of the Nose Throat and Ear in the School of Medicine of the University of Kansas, died at his home at 1015 Quindaro Boulevard, Kansas City, Kansas, on Wednesday, October 16th, from the effect of carcinoma of the stomach.

Dr. Emley was born in 1874. He graduated from the University of Kansas, with the degree of A. B., in 1898. He then went to Rush Medical College and took the degree of M. D. in 1902. After this he spent a year in Augustana Hospital, where he worked under Dr. Ochsner. He then went to Wichita and engaged in general practice until the fall of 1905, when he was made Associate Professor of Pathology and Bacteriology in the University of Kansas.

During the years of 1909 and 1910 he was in charge of the traveling tuberculosus exhibit and visited practically every town in the state situated on a rail road.

His lectures were very clear and were very well received.

By this work he placed the state under great obligation to him. He resigned his position in the department of Pathhology in the spring of 1911.

The summer of 1911 was spent in graduate work in Chicago. He returned to Kansas City in the fall and was associated with Dr. J. E. Sawtell in the practice of diseases of the nose, throat and ear.

His failing health caused him to visit St. Mary's Hospital at Rochester, Minnesota, early in the summer, but he failed rapidly after being operated upon there.

Dr. Emley was a student of marked ability easily excelling his class-mates in the rapidity, ease and the completeness of his grasp of a matter. As a writer he reported some creditable researches and his style was clear and lucid. His last article published in this Journal on Medical Education in Kansas, concerning medical education in this state illustrated his remarkable abliity to get at the essential of a matter and present his views in a clear vigorous style.

His wife and five children survive him.

M. T. S.

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REVIEWS.

Duodenal Ulcer—Treatment Of.—Dr. Vautrin, in Revue de Chirurgie, Paris, remarks that as a duodenal ulcer is of peptic origin, it follows that when the irritating hydrochloric acid can be kept away from it, the ulcer will heal. This is often possible by medical means, dieting to reduce production of acid, plus ingestion of alkalies to neutralize what is on hand. Under systematic perseverance with these measures he has cured patients with no sign of recurrence for eight or ten years to date. Old chronic ulceration with hard edges will never yield to medical measures alone, while it is a constant source of danger. The simplest, quickest and most effectual operative means to prevent further corrosion from the gastric juice is to shut off the duodenum entirely. A gastro-enterostomy alone does not answer the purpose unless the pylorus is already impermeable. The exclusion should be done 2 or 3 cm. above the tumor, in sound tissue. He throws a ligature around the trunk of the gastro-duodenal artery to ensure against hemorrhage and does this also as a precautionary measure when only gastro-enterostomy is done. He reports a case of hemorrhagic duodenal ulcer with symptoms recurring during two years

and during the following year there was severe hemorrhage from the ulcer on six occasions. The duodenum was severed close to the pylorus, the stumps were sutured separately, followed by gastro-enterostomy. The patient, a woman of 42, was thus cured at one stroke of all disturbances and has been in good health since. She still takes pains to conform to a diet that keeps the tendency to hyperchlorhydria under control.—Journal of the Medical Society of New Jersey.

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The Value of Enterostomy in Ileus.—L. H. Taylor, Washington, D. C., Monthly Cyclopedia and Medical Bulletin, July, 1912. Noting that the early spontaneous formation of a fecal fistula frequently exercised a very favorable influence on cases of peritonitis of appendiceal origin, Taylor employed enterostomy in severe cases of ileus with very good results. In these cases the indications are diminishing peristalsis and a change in the character of the vomitus. The degree of peristalsis he believes, can be observed by auscultating with the stethoscope. When the vomitus loses its sour gastric odor and begins to become brownish enterostomy is advisable. Under local anaesthesia or a very light narcosis the loop of gut near the lower end of the ileum is brought to the surface and an opening made in it through which a drainage tube is introduced. In appropriate cases in which the abdominal muscles have not been stretched beyond their limit of tonicity and in which the intestines still possess some power, the relief is immediate.

The author from a study of 20 cases, concludes as follows:

1. Enterostomy offers an excellent chance to a class of ileus cases formerly always fatal.

2. It should be performed before intestinal paralysis is complete and before the abdominal muscles are stretched beyond their limit of tonicity.

3. The lower ileum should be the region of election for the operation, and a tube of not less than 5-16 inch inside diameter used for drainage.

4. The opening should not be made in the colon.

5. Old people, fat people, and people whose abdominal muscles are weakened from any cause offer an unfavorable prognosis.—American Journal Surgery.

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Anti-Typhoid Vaccination.—Major F. F. Russell, U. S. A., Washington, D. C., (Journal A. M. A., October 12), uses the immunity produced by small-pox vaccination for purposes of comparison, and shows that anti-typhoid vaccination is, contrary to

what was at first supposed, almost, if not quite as effective. Kitasato's figures for Japan show that immunity from small-pox has largely disappeared after ten years, and it is quite possible that from anti-typhoid lasts nearly as long as that, under equally favorable conditions. He describes the method used in the U. S. Army, which has been employed in about 400,000 doses. The vaccination was obligatory and was very thoroughly carried out, thus obviating any criticisms that it was done only on a selected class who would be likely to avoid exposure. Typhoid fever has been practically abolished in the Army, only five cases in the first four months of present year, and only one in a person who had been vaccinated. The other cases were in newly enlisted recruits. In fact, he says, it is difficult to conceive of a more complete and thorough-going test and the results are evident. Russell believes that anti-typhoid vaccination has an extensive field of usefulness in civil life, especially in hospitals and institutions, industrial establishments, camps of laborers, and among persons patronizing summer resorts or traveling.

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Anti-Typhoid Inoculation.—The experience in the Massachusetts General Hospital with anti-typhoid inoculation is reported by L. H. Spooner, Boston (Journal A. M. A., October 12), who describes his techinc. In debilitated patients sometimes the reactions are severe, and he has discovered that latent and chronic disease of a non-typhoidal character may be made active by an inoculation. He has avoided inoculation in such individuals, but in general the reactions have been mild. During the first year the work was limited to the Massachusetts General Hospital, but since then the inoculations have been performed among nurses and other exposed individuals in twenty-four hospitals in Massachusetts, with a very marked reduction of morbidity. He says in conclusion: "Frequent injections of small amounts of a low-virulence vaccine cause slight inconvenience. They seem to produce a protection among nurses, who are eight times more liable to the disease than the average individual. Their morbidity, under ordinary conditions, is 1.4 per cent, or nineteen cases among 1,361. Only two cases developed under these modified conditions. Case morbidity among the uninoculated in these hospitals is nearly nine times greater than among the inoculated, subject to similar conditions. No permanent untoward effects have arisen from over 5,000 injections. The blood picture indicates a certain protection, lasting at least two and a half years. The use of this

means of protection has been shown to be safe in two epidemics and very efficient in at least one of them."

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Sodium in Origin of Gout.—Cohn presents arguments and relates experimental and clinical experiences which he thinks justify the conclusion that gout is the result of derangement of the metabolism of sodium and potassium and suggests that abstention from soduim is an important therapeutic measure. Potassium, on the other hand, counteracts the injurious influence of the sodium and should be given systematically. He has taken the potassium salts himself and given them to patients for weeks and months at a time and never witnessed any injurious by-effects, while they displayed a marked influence in attenuating the gouty process.—Kentucky State Medical Journal.

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MISCELLANEOUS

Joker in Drug Bill.—It was thought that the so-called Shirley Bill passed by the last Congress and approved by the President, would be a sound patch over the hole which the supreme court knocked in the Food and Drugs Act. You will recall the fact that the court decided that false statements on the label of a patent medicine applied only to the composition and not to statements as to the powers or value of the remedy. The Shirley Bill refers directly to "false and fraudulent" statements in regard to claims for the remedy. Dr. Wiley says that this is a joker. He says that the courts will hold that the words go together and that it must be proved that any statements on the label referring to the actions of the remedy, or claims for its powers, are both false and fraudulent, not either one or the other; the difficulty will be that it will now be necessary to prove two different crimes instead of one. Dr. Wiley may be correct; he certainly knows the crookednesses of that patent medicine game and the various sorts of frauds that can be worked. It looks as though the public has been sold another gold brick by Congress!—California State Journal of Medicine.

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The Respective Roles of Theory and Observation.—In connection with malaria, Laveran's name will ever be remembered as the discoverer of the parasite, but the practical application of the knowledge Laveran gave us was without significance until Manson's mosquito-malaria theory was enunciated. It has been the same with many similar discoveries. Waller in Lon-

don, for instance, saw the leukocytes leave the blood by passing through the capillary walls and gain the surrounding tissues; the fact, however, remained a mere physiologic observation, and it was not until Cohnheim showed the pathologic meaning of the extrusion of the leukocyte that the significence of the observation was manifest. Again, Lister gave us the practical application of Pasteur's researches. On the other hand, modern science is attempting to explain Jenner's observation concerning small-pox, and the physiologist's observations of to-day are explaining scien tifically the meaning of the dietary laws of Moses.—Journal Tropical Medicine and Hygiene.

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We confess a feeling of relief at the announcement made by Dr. R. H. Quine, at the Royal Sanitary Institute Congress, recently held in England, that the typical Englishman is not so devoutly weeded to "his tub" and bahth" as our perusal of British society fiction had led us to believe. The stoicism with which our English friends were supposed to take their morning dip in water of icy coldness had excited our admiration if not our emulation. It is good to know that they are not so very much better than we after all—and it is a real comfort to realize that the American woman is cleaner than the English woman, and that the American man is only a little less clean than the latter.—Medical Standard.

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COTNER CONVICTED IN SUPREME COURT.

J. W. Cotner of Lebanon, a "Suggestive Therapeutist" and "Magnetic Healer" was arrested on complaint of Dr. H. A. Dykes, Secretary of the State Board of Medical Registration and Examination in December 1991, and convicted on seven counts in the District Court of Smith County. He appealed to the Supreme Court and the decision of the lower court was affirmed.

In rendering the decision, among other things, the Supreme Court says: "The act of this state relating to medical registration and examination is one of a series devoted to the conservation of the public health. The state is especially interested in the protection of sick people from empiricism and from charlatanry; from the quack who is ignorant of healing and the faker who is an adept at swindling. Consequently, the legislature has provided that any one proposing to practice medicine must apply to the State Board of Medical Registration and Examination for leave, prove his qualifications, obtain a certificate of authority, and register it in the county of his residence, before assuming the duties and exercising the privileges of a physician. Should he un-

dertake to practice without a certificate, he is guilty of a crime and liable to punishment. The subject is of such moment and gravity, and the legislature has dealt with it so carefully and so seriously that a plea that the taking out of a certificate had been inadvertently overlooked would be an affront. Unless he be of weak mind, whoever ignores the statute does so wilfully and without any reason to expect acquiescence or toleration on the part of the authorities. Enforcement of the law is not left to private initiative or the prompting of mercenary motives. The duty is expressly enjoined upon the secretary of the board of registration and examination and all other law officers may be expected to co-operate, as in other cases of infraction of the criminal law. A prosecution is not a mere admonition to take out a certificate or else desist from practice. Its' purpose is punishment.

The life, health and financial resources of individual men, women and children were to be protected from ignorance and imposture. Each repetition is a new peril and instead of applying to a continuous course of conduct, the statute specifies and condemns each impulse to the very end that it may not unite with others in swelling a common stream of action.

"The judgment of the District Court is affirmed."

Secretary Dykes has rid the state of almost every faker, including the so-called "Chiropractors", "Suggestive Therapeutists," "Magnetic Healers," and each of these so-called systems has been disclosed and subjected to the State Board of Medical Registration and Examination by the Supreme Court of Kansas within the past year.

Cotner has jumped his bond and has gone to Texas where the State Board should look after him.

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Health for Sale.—One of the most interesting and important papers presented before the Fourth National Conservation Congress, which met last week in Indianapolis, was written, not by a physician or a sanitarian, but by a business man, Mr. E. E. Rittenhouse, of the Equitable Life Assurance Company. An abstract of his address appears in Society Proceedings in this issue. Mr. Rittenhouse, in the opening paragraphs of this address, recognized the crucial point in the present situation. He said: "It takes money to carry on a great educational movement and it takes money to conduct a public health service. The war between preventable disease and death is therefore a struggle between the dollar and the death-rate." These words should be placed before every citizen, for his instruction and as a warning. With our present-

day knowledge of disease, good health is a commodity which can be bought, if our cities, counties and states are willing to pay the price. For $1.50 per capita per year, any community can practically banish those diseases which we now have the means of preventing and can greatly reduce the number of deaths from all causes. One dollar and a half per year! Not quite half a cent a day to save life from destruction by known causes! Three cents a week, twelve and one-half cents a month, to protect each man, woman and child from disease, which we know how to prevent and which we know will exact a toll of many lives during the next year and all succeeding years until proper preventive methods are inaugurated! A pitiably small sum, one thinks. Yet how much are our most advanced commonwealths spending for this purpose? Pennsylvania heads the list with 48 cents per capita, per annum; Arkansas, at the bottom, does not spend a cent; New York spends 1.7 cents; Massachusetts, 4.2 cents; Indiana, 1.8 cents; and so on. In 1911, fifty of the largest American cities with a total preventable death-list of 117,724, spent an average of 30 cents per capita to prevent disease, and $1.65 per capita to prevent fires. If we could have in every city as good a sanitary service as we now have fire protection, many lives that are now needlessly sacrificed, could be saved. The people can have such protection if they want it and if they will pay for it. Safety from disease can be obtained just as we obtain safety from fire and from thieves. Health can be secured if society will foot the bill.

—Journal A. M. A.

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CLINICAL NOTES

SURGICAL SUGGESTIONS.

Splinters of hard wood, like pieces of glass, may become encysted in the tissues, and can be often drawn out whole by one end. But soft wood, and especially old wood, breaks on traction, and unless the wound is made large enough to expose it all, even very large fragments may be left, unrecognized, in the tissues.

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Ichthyol is helpful in the treatment of chronic non-suppurating paronychia. The underlying cause of the affection must be sought—syphilis, eczema, or favus of the nail, the use of caustic alkalies on the hand, etc.

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Hemolysis tests are desirable before selecting a donor for transfusion, but if the case is of great emergency this may be dispensed with, since hemolysis is unlikely if the donor is free from

malignant growth and tuberculosis. Syphilitic taint must of course be excluded.—American Journal Surgery.

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Diagnosis of Rupture of the Spleen.—It is not always possible to differentiate between rupture of the spleen and rupture of the kidney. The pressure resulting from the accumulation of blood from a ruptured spleen may cause urinary symptoms closely resembling those found in rupture of the kidney.

In rupture of the kidney, it has been noted in several cases that on careful rectal examination there could be distinctly felt an elevation of the posterior parietal peritoneum of the left side, due to the hematoma, which symptom is absent in splenic hemorrhage.—McCoy, in the Journal of the Medical Society of New Jersey.

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RECTAL HINTS.

Examine your patient's rectum with finger and proctoscope. You will be surprised to find how often you will discover unsuspected conditions. Use a finger cot or rubber glove, well lubricated.

You will find it easy to insert a proctoscope if the patient is on his knees, resting his left shoulder on the table, as near his knees as possible. This throws the buttocks well up. Have the obturator in the proctoscope. Lubricate the tip freely with petrolatum and insert very gently, first with a slight tilt down, then gradually upward. Have plenty of light to illuminate the interior. An electric head lamp is very satisfactory, if you have no electrically lighted proctoscope.

If possible, have the patient take a saline the night before examination. If, at the time of examination, fecal material is present, wash it away with irrigation. Do not attempt to examine with the rectum filled.

When, with the finger in the rectum, you palpate a prostate, be sure it is the prostate.

A minute history is essential. If constipation exists, ascertain its duration and severity; if diarrhea be present, the number of diurnal and nocturnal movements, also their character.

In diarrhea it is well to find out if your patient has ever been in the tropics. Amebic dysentery is more common than one would suppose. After examining such a case, wash your hands in alcohol.

Remember that it is possible to penetrate the peritoneum through the rectal wall. Should this accident happen, don't trust to expectant treatment. It is always disastrous.—Jerome Wagner, M. D., International Journal Surgery.

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THE APPENDICULAR LIVER.

DR. C. C. NESSELRODE, Kansas City, Kansas,

Read before the Northeast Kansas Medical Society, October 24, 1912.

From its situation the liver receives the frontal attack of both toxines and microbes, not only from the appendix but from the entire portal drainage area. The appendicular veins and the drainage of the portal vein carry microbes and toxines to the liver continuously. During an attack of acute appendicitis the amount of both the toxines and microbes is greatly increased. Because of the very different action of toxines and microbes, it is necessary to distinguish between toxic-hepititis and suppurative-hepititis.

Soon after the onset of an acute attack of appendicitis the liver may be effected by the toxines which are carried more rapidly than the microbes; there is an actual change in the hepatic cells which deserves the name of toxic-hepititis. This toxic-hepititis does not suppurate. It is the actual lodgement of microbes, either in the form of free microbes or infected emboli that give rise to suppuration either diffuse or in the form of multiple abscess. This constitutes suppurative-hepititis. Before discussing these two distinct forms of appendicular liver we will report two cases, representative of these two types.

Case 1.—Mr. S., came to my office September 25th, with the following history: Age 29, married, wholesale liquor dealer, past history negative, family history negative. Since childhood he had attacks of abdominal cramps usually relieved by free vomiting, does not know how many of these attacks he had. Has never been confined to bed with these attacks except once, when he was in bed for three days. He insists that he never knew the pain to become localized, and never had any localizing tenderness, does not think that he had any fever. Is just getting over an attack at the present date. Examination, temperature normal, pulse

80, head and chest negative, abdomen negative, no tenderness on pressure in any part of the abdomen, urine negative, leucocytes 11,000. One week later I saw him at the home in the midst of another of these attacks. He had no temperature and he had no abdominal pain except a sense of discomfort and sense of fullness in the upper abdomen. He insists that there is no abdominal tenderness and surely there was no abdominal rigidity. I saw him twenty-four hours later with a temperature of 102, still no localizing symptoms to be made out. The morning following his temperature was 101, leucocyte count showed 24,000, 89% polys. The only thing to be made out on examination was an increased area of liver dullness. The upper limits of dullness were almost to the level of the right nipple, absolutely no rigidity or tenderness in the right lower quadrant. There was some uncertain rigidity and tenderness, however, in the upper right quadrant. He had at this time a very slight tinging of the sclera of the eye but no apparent tinging of the skin. The evening following this examination he had a slight chill and was ordered sent to the Hospital. During the first day at the Hospital which was the fourth day of his illness, he had a chill and that same night another. Each of these chills was followed by high temperature and profuse sweating. A leucocyte count made during the day showed 22,000 with 87% polys. The morning following, which was the morning of the fifth day, his abdomen was opened with right rectus incision a little above the level of the umbilicus. We found a distinctly inflamed appendix with a small perforation and abscess within the messentery. This abscess did not contain to exceed a dram of pus. The mesentery was much swollen and inflamed. Appendix removed and drainage established. He progressed slowly, having some temperature with some slight infection of the wound. On the night of the fifth day he had a chill. The morning of the sixth day the area of the liver dullness having lessened but slightly, leucocyte 26,000 it was decided to drain the gall-bladder. This was done through a very small incision just above the former incision. The gall-bladder was slightly distended and contained a bile that was full of mucous and many floculi. Cultures were made from this bile on agar slants, but showed no organisms. The patient remained a good deal as he had been for the few days preceding this second operation, except that he had no chill. At the end of six days however, his evening temperature was normal, his leucocyte count 11,000, and has remained normal up to the present date. The drainage from his gall-bladder the first several days, contained large quantities of mucous but now

and for several days past, has been apparently normal. He is at this time making a very satisfactory convalescence.

Case 2.—Mr. B., age forty-two, married, admitted to surgical service of Dr. G. M. Gray, St. Margaret's Hospital, June 2, 1907, suffering with an acute appendicitis of three days standing. He gave a history of previous attacks, nothing unusual in the history of this three days illness except the fact that some twelve hours before entering the Hospital he had a chill. He was taken to the operating room at once and a gangrenous appendix removed, drainage established. On the third day the chill followed by temperature of 104 and profuse sweating. A leucocyte count made at this time showed a total count of 29,000, no differential count made. His temperature subsided in the course of a few hours but the day following he had another chill with an unusually high leucocyte count and temperature. The wound looked good. The condition of the abdomen perfectly satisfactory, the drainage was not very profuse, the areas of the liver dullness was considerably increased, the increase being upward, in fact the question of pleural effusion was discussed. He continued to run a very inregular temperature curve, accompanied by a high leucocyte count, no pain and no localizing symptoms except the increased area of liver dullness. On the seventh day an aspirating needle was introduced into his right pleural cavity and six ounces of a perfectly clear serous fluid extracted. We were then convinced that we were dealing with a pylephlebitis or multiple abscess of the liver of portal origin. However, on the ninth day an exploratory incision was made in the upward quadrant of the abdomen in the bare hope that we might be mistaken and that the evident infection might be of such a location that drainage might be established. The abdomen showed no signs of peritonitis and our findings only tended to confirm our diagnosis of multiple abscess of the liver. The gall-bladder was not distended and could be easily emptied by pressure. This man continued to have these irregular paroxyms beginning with a chill and then high temperature and profuse sweating. He died near the end of the fifth week. Never was jaundice a marked symptom and yet there was distinct coloring of the sclera. The area of liver dullness extended upward to a level of the nipple and there was marked bulging of the liver area. Slightly tender to pressure but never markedly so. The appendix temperature chart shows the irregularity of his temperature curve, the dots marking the time and number of chills. The chart however, fails to show the high temperature that always followed immediately upon the chill, because the tempera-

tures here recorded were taken at a regular time each day while the chills occurred at very irregular intervals. Following his death an autopsy was done by myself with the following findings:

Abdominal cavity showed no signs of peritonitis. The spleen was slightly enlarged, the liver very much enlarged, surface smooth.

The cut section shows hundreds of small abscesses from the size of a pin head to that of a pea. The mesentery veins in the region of the appendix were thrombosed but on opening these veins we find the thrombus to be of a soft and necrotic nature, appearing more as a greenish purulent semi-fluid. The main trunk of the portal vein was not thrombosed but many of the portal venules of the liver were found to contain much the same character of fluid as was found in the mesentary veins of the appendix.

These two cases illustrated the acute type of appendicular liver so well, as laid down by Dieulafoy. The toxic-hepititis usually appears soon after the onset of attack. There is usually slight tinging of the sclera of the eye with perhaps a very slight tinging of the skin of the face. It is very exceptional for the jaundice to become general. The faeces remain colored. The urine is only moderately bile stained, and in most cases there is enlargement of the liver most marked upward. The jaundice usually disappears within a few days after appendectomy.

Dieulafoy reports two cases in which the slight jaundice persisted for several months after an attack of appendicitis and disappeared only when the appendix was removed at the end of this period. He has suggested that these cases of toxic-hepititis might bear some relation to the etiology of cirrhosis of the liver. Dieulafoy had an opportunity to examine some of these livers microscopically. He states that there was an accumulation of very fine fatty granules in the interior of the liver cells, especially near the center of the lobule.

One detail was interesting to note, viz., that accumulation of fat in the endothial cells and in the interior of the capillary vessels a large number of leucocytes charged with fatty granules. There was no necrobiosis in the liver cells, in short he found in the liver, lesions of granule, fatty degeneration of the centro-lobular hepatic cells, that is, lesions due to super-acute intoxication.

As to the second or more serious form, suppurative-hepititis. The case reported above shows a fairly typical history with the exception, that usually the chill which marks the invasion of the liver comes on at a later time. Dieulafoy says that he had never known a case to come on earlier than the sixth day and usually it is the tenth.

It is now generally recognized that the liver, like the kidney, has passing through it at all times bacteria. That as long as the liver is normal and the bacteria not of too virulent a nature, no damage results. But, if you stop to consider that in every case of appendicitis, the appendix becomes converted into a closed cavity containing many bacteria and remembering the effect that this closed cavity has upon the virulence of the inclosed bacteria, it is easy to see the danger that every attack of appendicitis has upon the liver. These bacteria are carried to the liver by the portal circulation, in the ordinary case as free bacteria, but in case the mesenteric veins of the appendix become thrombosed, then the bacteria are carried in infected emboli. In the case of the free bacteria the liver may be able to pass them through to the bile ducts with no damage or at least only a cholongitis resulting. In the case of the infected emboli, the embolus becomes lodged in the smaller portal venules producing a thrombosis of the small venules with the resulting abscess. The size of this abscess is determined largely by two things: The size of the embolus and the length of time the patient lives, usually the embolus is a very small one and lodges in the smallest of the venules and being a small focus the resulting abscesses are usually very small. If one stops to consider the anatomical arrangement of the portal circulation it is easy to see why the number of these abscesses is so great and their distribution throughout the liver so general. In the case reported above the abscesses were numbered by tens and almost by hundreds.

There is one condition which we have referred to very briefly above and which has been very largely written about in the last few years, that is, the relation of cholangitis and the resulting gall-stones to appendicitis. We do not care to discuss this except to say that as an acute complication of appendicitis its importance is very small as compared with either toxic-hepititis or suppurative-hepititis.

In conclusion, it is well to remember that both these types of hepatic-infections are always consecutive to the acute phase of appendicitis. The first usually has its onset during the second or third or fourth day of the attack. The second any where from the fourth to the tenth day. In either case there is time, if the attack is recognized early, for surgery to intervene and save the liver such an attack. Hepatic infection is one of the most terrible complications of appendicitis and if these cases are to be saved the appendix must be removed before such an infection takes place, for we are powerless to avert the evil, once it has established itself.

Every practitioner of medicine should have this danger thoroughly in his mind before he advises any patient to await an interval operation for appendicitis.

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DISLOCATION OF THE LENS AND PERFORATION OF THE CORNEA.

DR. R. S. MAGEE, Topeka, Kansas.

Read before the Medical Association of the Southwest, October 8, 1912.

The consistence of a mature traumatic cataract depends upon whether the gradual loss of the watery elements of the lens by absorption keeps on or not. If the loss of the water continues, nothing remains but the nucleus, leaving a flat, cake-like mass. The lens diminishes in volume until in some cases it is transformed into a thin, transparent membrane. The two layers of the lens capsule come into apposition, and if they remain transparent the vision will return at least in some measure—a sort of spontaneous cure of the cataract. If not, an opacity results, obscuring the vision.

Lime salts may be deposited, says Fuch's, in the lens substance, giving it a yellow or chalky white appearance—also cholesterin which would present glistening points. This shrinking process may make the lens tremulous. In proportion as the lens diminishes—it affects the zonula of Zinn—putting it upon the stretch, later causing atrophy of its fibres. Consequently the attachment of the lens becomes imperfect so that it shakes with the movements of the eye. Spontaneous luxation of the lens may take place through partial or total rupture of the zonula. The lens may be tilted just a little, (subluxation) backward or may leave its place altogether—luxation. Two forms of luxation are usually mentioned—prolapsing into the anterior chamber—this is forwards or receding into the vitreous—backwards. But I want to call your attention to two others both of which are due of course to trauma and rupture of the globe one in the ciliary region with the escape of the lens underneath the conjunctiva; the other still farther back, posteriorly with the escape of the lens substance into orbital cavity.

Subluxations are very likely in time to change into complete luxations—the vibrating lens constantly pulling upon the Zonula and gradually causing it to atrophy.

Luxated lenses may remain transparent for a time but usually very soon become opaque. Complications arising from dislocated lenses are irido-cyclitis and increase of tension—glaucoma.

The most dangerous form of lens dislocation is into the anterior chamber. In this case the cornea becomes opaque wherever the lens is applied to its posterior surface and then the eye for the most part begins to undergo speedy destruction. Also contact with the iris, setting up an iritis by irritation leading to an iridocyclitis.

Case 1.—Wm. D. , aged 56, Kansas City, Kansas, a car carpenter, received an injury to his right eye in October, 1904. The eyeball was ruptured in the upper quadrant of the sclerocorneal region. The aqueous chamber and seemingly the whole eye was filled with blood. Underneath the conjunctiva was a globular mass the size of a pea and was freely movable and looked like a large drop of oil. I opened the conjunctiva and removed the mass and found it to be the lens—the eye was sightless and because the globe was filled with blood I advised enucleation. This was refused. In three months he returned with a slight injury, which he claimed to have again received to this same eye. I could find none, but did find that sympathetic trouble had begun in his other eye. He was then ready to have the old injured eye removed, which I did but it was too late. Sympathetic trouble which had begun, progressed rapidly, going on to total blindness.

An interesting feature developed in this case. A few weeks after the first injury he was solicited by an Insurance agent for an Accident Policy. He was written up—never paid a premium—giving his note. After loss of vision he sued the Insurance Company for the full amount of policy and after two or more years of litigation in the local courts and the case being carried to the State Supreme Court, the plaintiff won his suit. This item of information while having no direct bearing on the subject of this paper any further than this—that it is a suggestion that applicants for accident insurance would be much safer and better risks to the insurance company if subjected to a thorough medical examination before their applications were finally accepted.

Case No. 2.—Mr. G., aged 61, a blacksmith of Wamego, in 1908 was struck in the eye by a flying piece of steel. The eye ball was ruptured in the inner and upper quadrant in the ciliary region, resulting in the escape of the lens underneath the conjunctiva. It could be easily seen and felt. Very little hemorrhage occurred in the eye. The injury had occurred several days when I saw him. I removed the lens—the wound healed—had considerable vision in the eye, and it gave him no further trouble. In this case as well as in Case 1, the lens could be moved about freely un-

derneath the conjunctiva like a ball. It was a clear and a semi-solid globular mass pushing out the conjunctiva as if it might be a tumor. No color, resembling in appearance a bubble of air or drop of oil, but pressure of the finger showed it to be a mass somewhat solid and not inclined to separate when pressed upon. A gelatine capsule, shaped like a bead or button, makes a good illustration as to how it looked.

Case No. 3.—Mr. P. age 34, clerk, American, gave the following history : Twelve years ago lost the sight of left eye. Does not recall having received an injury at that time. Two months ago discovered that he was able to again see some out of this eye. Said that something kept moving backward and forwards in front of the sight like a shutter and that when this "moving thing" on the inside of his eye passed to one side he could see for the moment and then it would be covered up. This annoyed him and the annoyance increased and he was conscious of the fact that the flashing of the light in and out of this eye was having a decided unwholesome effect on the good eye. An examination showed an opacity of the lens—dense white and shiny and that it was movable from side to side in a pendulum-like fashion. Also a tremulous iris. I advised him to wait a while and watch developments. I told him if this floating lens should break loose to return and report. In about two or three weeks he came in again. It had dropped down. On working with the eye and using a mydriatic the lens slipped through the pupillary space and descended into the bottom of the aqueous chamber. Fearing to jostle him about much he was immediately prepared for operation and the lens extracted. It was difficult in making the corneal incision to get by the lens. As soon as the cornea was opened and with the escape of the aqueous—the lens started to go back through the pupil. Immediately the iris prolapsed. With the introduction of the wire loop, the lens was delivered. The prolapsed iris was removed and the usual toilet of the wound was made and the operation was completed. Such an operation is much more difficult and complicated than a cataract extraction because of the fact that there is no separation between the aqueous and vitreous chambers—the eyeball is all open and the loss of the vitreous is most likely to occur. Vision in this eye with plus 10D reads the finest print.

Case No. 4.—Martin, brakeman, was climbing on top of a box-car when he caught hold of the grab-iron on top of the car. It gave way letting him fall backwards striking the ground with the iron still in his hand. The end of the iron struck him on the cheek

making a gash at outer and lower corner of the right eye. The eye presented the picture of a panophthalmitis. The eye was filled with blood. No opening in the anterior part of the eye ball. The eye ball was removed. A rent was found on the posterior surface and the lens together with the vitreous contents had escaped into the orbit behind the conjunctiva which accounts for the great swelling of the eye. The force of the injury was so severe as to cause a rupture contra-coup of the eyeball.

Case No. 5.—Mr. W., age 28, while cutting rivets, a piece of steel struck the eye with great force. No external laceration of the globe occurred but an extensive ecchymosis and hyphema. In a few days the blood in the anterior chamber cleared up. It was then seen that the iris was rent and detached for two-thirds of its circumference and that the lens was lying in the vitreous chamber well down inferiorly. The patient was kept in bed with ice pack and watched. An irido-cyclitis developed—later the eyeball had to be removed. Here the injury was of a double nature—the whole of the iris almost detached together with the dislocated lens—made destruction of the globe inevitable.

Perforation of Cornea.—Perforation of the cornea frequently occurs from severe injuries—fragments of steel or broken glass striking the eye with considerable force and then dropping back—not going into the eyeball. Perforations also may be caused by various straining efforts such as crying, sneezing or coughing or force exerted in examining an eye. When such perforation occurs, the aqueous humor escapes and a prolapse of the iris follows. The aqueous chamber is obliterated. The iris and lens lie up against the cornea, and at the point of opening a portion of the iris will protrude. When the opening closes, if the iris be allowed to remain there it becomes adherent, remains prolapsed and becomes incorporated in the scar—a condition known as anterior synechiae and the cicatrix forms a dense white scar—opacity of the cornea—known as adherent leucoma. But this is not the only thing that will happen. The pupillary edges of the iris will become adherent—a plastic exudate will be thrown out and the pupil will become closed—resulting in a white pupil and blindness will follow. Occasionally the perforation fails to close and a fistula of the cornea results. This of course exposes the eye to a subsequent inflammation—it is a leaky eye and jeopardizes its safety. All of this can be prevented and is the fact to which I wish to call your attention. If such an eye comes to you in which you suspect a perforation of the cornea—examine it closely and you will find one or all of three things; first, a shallow anterior

chamber. Second, hyphema—blood in the anterior chamber, and third, at the site of the perforation a globular mass, freely movable, blackish or grayish, depending on the length of time elapsing since the perforation. This mass is the protruding iris. Do not attempt to put it back—it is dead from strangulation—in every sense of the word, a strangulated hernia. If you should put it back it will come back out again, or adhere to the under side of the cornea or still worse, carry into the interior of the eye infection, which will destroy the eyeball by suppuration. These injuries are always emergency cases, and demand immediate attention. Now what should be done? It is an infected eye having had ample opportunity to become infected by the patient from his finger nails or soiled handkerchief, and must first then be thoroughly cleansed and I want to emphasize this thoroughly.

First, cocainize, then with the iris forceps and scissors clip off the portion of iris protruding—first pulling it out far enough so that when it is clipped off the freed ends will return well back into the eye. The corneal wound can now close—which it will do and could not do before because held apart by the protruding knuckle of iris. A small linear scar will be all that will be seen to mark the site of injury—instead of a large white opacity. The vision will be practically as good as before the injury. The iris will now be free. If it had become incarcerated in the wound, with attempts at dilation or contraction on exposure to the light there would have been constant nagging of the iris—producing an inflamed and irritated eye. The eye cared for in this way will soon get well. If not, will drag along for weeks and months.

No perforation of the cornea however slight should be considered insignificant, but should be carefully examined and watched. The perforation of the cornea may be complicated by the injury to the lens and ciliary body. If such a thing occurs the lens will most likely have to be removed, or if broken up, allowed to remain and absorb in its own time—depending on the conditions present. It is often much better to leave it alone, as a blind eye from a traumatic cataract is much less trouble to the patient than an eye without a lens when the vision of the eye on the other side is perfect.

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RABIES.

DR. W. T. McDOUGALL, Kansas City, Kansas.

Read before the Northeast Kansas Medical Society, October 24, 1912.

In reading this paper on rabies, it is not my intention to take up much of the society's time; hence I will not attempt to go, to

any great extent, into the symptomology, pathology or value of the different methods of treatment.

I shall confine myself to a few remarks which I believe may prove of some interest to the physician, in connection with a disease which in spite of its comparative rarity, has been extensively investigated by scientists, and has come to be widely known to the general public.

This disease is one which has long been enshrouded in superstition and ignorance. There yet remain a few persons who are skeptical concerning, or even deny the existence of rabies as a distinct disease. The reason for this disease being so well known, is due without doubt to its peculiar and almost dramatic method of transmission; to its unusually long period of incubation; and to the violent symptoms and extreme suffering of its victims, together with the inevitable fatal termination. In mortality the disease has played but a small part as compared with the great scourges, tuberculosis, small-pox, and like diseases. Every year however, sees a number of victims, and there is scarcely a community that entirely escapes the worry and anxiety on part of some one of its members who has been exposed to the rabies and fear its onslaught.

The disease of rabies is of ancient origin, and accurate and detailed descriptions of its symptomatology have been handed down to us through the past centuries, carrying with them a mass of superstition and erroneous belief, especially as to the causation and treatment of the disease.

The mad-stone is still believed in and patronized in many sections of the country, and it is perhaps as well, or even better known to the laity, than is the pasteur treatment itself.

There are many who still believe in the spontaneous origin of the disease; that it is brought on by extreme heat, lack of water, and many other causes. From this haze of superstition, ignorance and hear-say, we find that most people have formed for themselves a mental picture of this disease which, in its fanciful distortions and spectacular settings, is not to be equaled by that of any other malady.

The disease of rabies occurs in almost all countries and there are but few animals not susceptible to intentional innoculations with the virus. Many points of similarity exist between rabies and other infectious diseases, and the conclusion seems unavoidable, but that it is caused by a micro-organism.

This micro-organism can be propogated in the central nerve tissue of living animals but not in dead ones.

The poison has been shown always to be present during in-

fection, in the brain, spinal cord and nerve trunk, and in some animals, as the dog for instance, in the salivary glands and saliva. In rabbits and in man this is very seldom the case. The blood, cerebro-spinal fluid, or milk, seldom harbor the virus and it is a well established fact that the virus travels for the most part ,if not exclusively, by the nerves themselves. Hence, if we wish successfully to innoculate an animal, the virus must be injected in such a way as to be certain that it will come into contact with injured nerve tissue, that is, injected into a large nerve trunk or into the brain itself. It is for this reason that when the virus is injected subcutaneously, the disease fails in the majority of cases to develop, and it is for this reason largely, that only about one case in eight develops the disease after being exposed through the bite of a dog known to be rabid. This of course refers only to those exposures which are left untreated, and allowed to follow their natural sequence.

Of the untreated, suspicious bites, that is those from animals only suspected of having the disease, we find that only about five per cent develop the rabies. This fact tends to show, I believe,that quite a large per cent of animals suspected of being rabid are not really so, but are suffering from other troubles. This brings us to the question of how to detect rabies in the dog.

There is a popular idea that a mad dog is a raging animal, with glaring red eyes and a frothing mouth, but this is seldom found in actual experience. In fact, a mad dog is a sick dog and one in which if we wish to accurately diagnose his disease, we must, as in other diseases, have him under observation long enough to note the different symptoms as they develop. I will mention just a few of the most characteristic symptoms of the disease as they appear in the dog. One of the most noticeable symptoms seen early in the disease is that of extreme restlessness. This may become so marked that he will wander away from home, his main object seeming to be to keep moving. During this period he seems to get some satisfaction in biting anything that comes his way. Other symptoms noted at this time are an abnormal appetite and some difficulty in swallowing. It is during this stage that the dog usually does his damage, and we are not always able at this time, from these symptoms, to correctly diagnose the case and distinguish it from some other troubles. Following this stage appear the more important symptoms from a diagnostic standpoint. These are the appearance of convulsions of a greater or less distribution, effecting the muscles of the throat, respiration, and becoming general.

These are followed by paralysis which almost always begins in the hind legs and extends upward. At this time the casual observer is more likely to think the animal to be suffering from an injury to the spine than from rabies. The paralytic type of the disease may be described as the early or onset of the paralytic symptoms, with a slight or absent stage of excitement.

There seems an idea prevalent among many physicians that the best and quickest way to determine whether or not an animal is rabid, is to have it killed and its head shipped to some laboratory for examination. This, however, is not the case. It has been my experience that the laboratory examination of the brain does not always yield satisfactory results.

When a physician sends his material to a laboratory for examination, he does so expecting to be told, not only when treatment is necessary, but more especially when it is not. From the ordinary examination we are unable to give him this latter information. The disease may be frequently detected in a badly decomposed brain but our failure to find it does not necessarily mean that is it not present. The point I wish to bring out here is that there are but two ways to determine when treatment is not necessary. The first, is to secure the animal alive and watch its symptoms. The second, is to have a careful examination made of a well preserved brain and if it is negative, to have it controlled by inoculation tests. If such an examination is desired, the head of the animal should be secured in good condition very soon after it has been killed, and a small piece of the brain or spinal cord removed and placed in glycerin to be used for inoculation tests. The rest of the head or brain is then to be placed in a 1 to 2000 bichloride solution and immediately sent for examination.

This latter method may be objected to upon the ground that in some instances it would cause a loss of time.

Before taking up the symptoms of the disease as found in man, I will state that while I have had considerable experience with the disease as it appears in animals, my observation of the disease as it is found in man has been confined to but a single case. While there are many points of similarity in the disease in both man and animals, I must necessarily in great measure, draw on others for its description. The disease presents itself in at least two clinical types—the furious or excited, and the silent or paralytic. In the excited or furious type, the patient usually shows some psychical change very early, becoming anxious and oppressed with a strange sensation of some impending danger. These psychical manifestations may be absent in some cases and in their

place may be itching and formication at the sight of the wound. Sometimes a strange sensation in the throat is complained of, with some discomfort in swallowing. Usually in a day or two after these prodromal symptoms, the grand symptom, hydrophobia presents itself. It arises from extremely painful spasms of the muscles of the throat and respiration, which are induced by an attempt to eat or more especially to drink. This progresses to the extent that any suggestion of the act of swallowing is sufficient in most cases to bring on an attack.

This symptom is due to a hypersusceptibility of the nerve cells to an external stimulus. Later when the cells become paralyzed this symptom disappears. The spasms do not long remain confined to the muscles of the larnyx, but soon become general and are usually clonic. In character they are so severe, it is said, that at times they have caused the rupture of a muscle. The mind is for most part clear, but at times there is apt to be maniacal seizures.

Increased salivation is present and vomiting is a frequent symptom. The strange sounds produced by the spasms of the muscles of the throat and respiration have given rise to the popular belief that the patient barks like a dog. Death may occur at this period, from convulsions, but more frequently paralysis develops and tends to relieve the patient from his suffering. It usually begins in the extremities and gradually extends upward until death is caused by paralysis of the center of respiration. In the paralytic type of the disease, the stage of excitement is absent and for this reason the disease is probably oftentimes incorrectly diagnosed. Here we may have as prodromal symptoms, high fever, vomiting, cramps and headache, and localized pains. In the bitten parts, paralysis then develops, accompanied with or preceded by pains in the effected parts. The paralysis invades the limbs, trunk, rectum, bladder, face, tongue and eye muscles. There is usually respiratory embarassment and the symptom of hydrophobia is not often present.. Death in these types of the disease may not take place for seven or eight days, while in the former type it usually takes place on the 3rd or 4th day.

I am going to take up just a few moments time in regard to the treatment. After the disease once develops there is no treatment of any value. However, in dealing with this disease, we fortunately have one in which the incubation period is, as a rule, quite long. In the majority of cases it is from 70 to 80 days, hence our treatment up to this time must necessarily consist in the producing of immunity during its long incubation period.

The principle upon which this production of immunity is carried out, is that of first modifying this virus in such a manner as to render it practically innocous to man. This is brought about by repeatedly passing the virus through another animal, usually the rabbit. When first transferred from the dog to the rabbit, the incubation period is usually about three weeks. After some forty or fifty passages, the incubation period is gradually shortened to about 6 or 7 days, and by no amount of further passage can this incubation be shortened. The incubation period is then fixed as to time, hence the virus is called fixed virus. It has now become exceedingly virulent for the rabbit, but it is practically innocous to man. In some of the newer methods of treatment this fresh virus is injected without any modification whatsoever.

I have had no experience in this method of treatment, although it has many points in its favor. The usual method of the anti-rabic preventative treatment consists in daily injections of an emulsion prepared from the spinal cord of the rabbit after it has died from an innoculation with fixed virus. The virus is strongest when the cord is fresh but by a process of drying, different strengths of virus are obtained, thereby enabling us to graduate the dosage as desired.

There are three schemes of treatment, mild, medium and intensive, depending upon the location or severity of the bite or wound. The general plan however, consists of 25 injections coving a period of 21 days. These injections contain about two and a half cubic centimeters of the diluted virus, which is usually supplied to the physicians each day ready for use. Its administration is as simple as that of any other hypodermic injection.

As to the efficiency of the Pasteur treatment, I will say that it is almost positive in its effect, only about one per cent of the cases so treated developing the disease as against 15 to 16 per cent in the untreated cases.

Of this per cent of cases where the disease develops in spite of the treatment, the majority are due to a lack of time in which to produce immunity, and not often to the failure of the treatment itself.

Serious ill effects of the treatment are so rare that they hardly deserve consideration. Records show that out of the administration of one hundred and seven thousand cases of Pasteur treatment, there have been but two deaths caused by what is called "Treatment Paralysis."

The ordinary administration of treatment causes but a slight reaction, the patient usually going on about his business in the

regular way and calling daily at the physician's office to receive the injection. Even children seem to stand this treatment very well, and the difficulties encountered are not a great deal more than would be expected in the administration of an equal number of any other kind of hypodermic injections.

In conclusion, I will say that it is not always necessary to send the patient away from home for treatment.

The local physician in attendance can easily procure the treatment and administer it himself.

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EPISTAXIS AS MET BY THE GENERAL PRACTITIONER.

J. H. JOHNSON, M. D., Coffeyville, Kansas.

Read before the Southeast Kansas Medical Society.

Late Professor Eye and Ear, College of Physicians and Surgeons, (now medical department of the University of Kansas) and late Professor Eye, Ear, Nose and Throat, Western Dental College, Kansas City, Mo., Oculist Mo. Pacific, St. Louis, Iron Mountain and Southern Railway Companies, Oculist Good Samaritan Hospital, Coffeyville, Kansas.

It is my purpose in this paper to briefly review epistaxis, taking up the etiology, symptoms, diagnosis and treatment, with the report of an interesting case, viewing the subject from the standpoint of the general practitioner, and I will endeavor to bring out some things which might be of use to him.

Epistaxis, which very few people escape, is a hemorrhage from the nose, popularly known as nose bleed, varying from a few drops to a continuous flow, endangering life, coming from the anterior or posterior nares. The chief vessels concerned in epistaxis are branches from the spheno-palatine, namely, posterior nasal, which ramifies over the turbinated bones and sends branches to the antrum and to the frontal sinus and to the ethmoidal cells. And naso-palatine, the artery of the septum. Twigs are given to the upper portion of the cavity by the anterior and posterior arteries, while the posterior part of the nares receives some from all branches, from the descending palate vessel. The veins form a dense plexus almost resembling cavernous tissue in structure. This condition is especially seen over the middle and inferior turbinated bones and on the lower part of the septum, this vascular tissue is favorable to capillary oozing or diapedesis. The physician should as early as possible locate the cause of epistaxis, this is necessary, as epistaxis is frequently a symptom only, or may be an expression of a local or a general pathological condition. Epistaxis may result from direct injury to the nasal structure by accidental or operative traumatism. Examples of accidental trau-

matism are blows, picking or scratching the nose. Operative epistaxis may be the result of the removal of new growths, parts of the turbinates or septum, probing in the nose, using a probe in the nasal duct, or from sloughs following cautery operations. Hemorrhage from the nose may also result from seriously jarring the head by falls or blows, or from fracture involving the base of the skull. Epistaxis may be caused from ulceration of the nasal mucus membrane from tuberculosis, syphillis, typhoid fever, diphtheria or the presence of foreign bodies. If the ulceration of the nose be near the junction of the anterior cartilage of the septum with the skin and just within the vestibule, epistaxis is more apt to occur. Varicosity of the veins of the nasal mucosa may sometimes be recognized as the cause of epistaxis. Some of the other causes are, acute and chronic rhinitis, telangiectasis, nasal tumors and adenoids. In growing children especially at the age of puberty, epistaxis is more apt to occur, and more frequent in children living in heated compartments. Poorly ventilated school rooms is undoubtedly responsible for many cases of recurrent nose bleed.

Epistaxis is thought by some to be hereditary, but this might be the result of an inherited predisposition. This is manifested by the frequency of epistaxis in the delicate and rheumatic rather in the strong and vigorous. Blood diseases such as leukemia, chlorosis, purpura, scorbutus, (scurvy), hemophilia, syphillis, pernicious anemia, and all forms of chronic anemias, or extreme plethora will be favorable to epistaxis. Hyperaemia from cardiac or vascular lesions, obstruction to the return of the blood from the head, as in tumors pressing on the viens of the neck, produces epistaxis, as does arteriosclerosis, chronic interstitial nephritis (Brights disease), cirrhosishepatis and hepatic disorders, resulting from malaria poison, stasis from lung lesions, and multiple telangiectasis of skin and mucus membranes. Two important heart lesions as etilogical factors, are valvular and cardiac hypertrophy. Epistaxis not infrequently occurs in the onset of certain fevers as typhoid and malarial fevers, also in diphtheria, scarlet fever, variola, measles and especially in the hemorrhagic form of all the eruptive fevers. The etiology of spontaneous hemorrhage from the nose of the new born is obscure, but is considered to be caused by hereditary syphilis. Epistaxis in women may occur as the result of pregnancy, and vicarious epistaxis in suppression of the menses has been reported' and also nasal vicarious menstration, (so-called), has appeared at about the time of the menses, and said to be brought on by certain psychological impressions. Suppression of the urine and sweat, obstinate constipation, cold extremi-

ties, mental excitement, violent exercise, severe vomiting, and violent respiratory acts, like strangling or coughing, (as during severe paroxysms of pertussis) and sneezing, are causes of epistaxes, ordinary gymnastic exercises have produced post-operative nasal hemorrhage. In balloon ascensions and mountain climbing it is a common event, (the rarified atmosphere being the cause), to have epistaxis.

The symptoms of epistaxis are as a rule simple and easy made out. A frequent prodromal symptom is a sense of fullness or pain in the head, which is relieved by the bleeding, common in children, especially boys; from four to twelve years of age, seldom seen earlier, and as it frequently takes place during the sleep, the symptoms may be obscure by the child swallowing the blood and later vomiting the same. In doubtful cases an inspection of the pharynx reveals the presence of blood-clots. The hemorrhage may originate from any part of the nasal fossa, most frequently from the vessels of the septum, usually from the anterior nares, and usually from one nostril coming slowly by drops. The hemorrhage seems to come in some cases from the ethmoidal veins, and possibly from other sinuses. The amount of blood lost is usually small but may be large, and generally ceases spontaneously in ten or twenty minutes.

The diagnosis of epistaxis is readily made except where the bleeding has occurred from the posterior nares during the sleep and trickled into the pharynx and swallowed. If vomited, it may be taken for hematemesis, if coughed up it may be confused with hemoptysis. It must be born in mind, before a diagnosis of hemorrhagic disease is made in the new born, that the source of the blood found in the vomit or feces is not from a fissured nipple or blood from the nose which had been swallowed.

To say that a man has epistaxis is no more scientific than to say that he has a fever. Hemorrhage from the nose is a symptom only, and to make a complete diagnosis, the physician must answer to himself at least, what is the cause of this symptom? Is it due to traumatism, ulceration, vericosity, acute or chronic rhinitis, tumors, poor air, a state of the blood, condition of the heart, lungs, liver, kidneys and blood vessels, beginning of certain infectious fevers? Do not over look the causative constitutional condition. In haemophilia the mucus membrane of the nose ranks first from which bleeding arises, but is not a frequent feature in the hemorrhages of the new-born. When spontaneously occurring in the new-born it indicates hereditary syphilis. Idiopathic nose-bleed in elderly individuals is most frequently a symp-

tom of contracted kidney or of arteriosclerosis and should not be passed over lightly, also look for valvular defects of the heart in habitual nose bleed, "It is stated sometimes to precede or to indicate a liability of apoplexy."

The prognosis in the majority of cases of epistaxis is favorable as the hemorrhage is usually trivial in character. The so-called idiopathic cases are not serious as a rule, and death is rare. The longer the bleeding keeps up the greater the tendency to stop spontaneously. The amount of blood varies, but usually stops short of danger, and ordinarily does not effect the prognosis in infectious diseases unless severe. If late in the disease it is always a bad sign, especially in diphtheria. Other than a tentative prognosis should not be made until the cause of the epistaxis has been ascertained. Infants are in the foot of the scale of tolerance, while pregnant and parturient women are at the top of the scale. From the loss of only four ounces of blood or less, infants have been known to die.

The methods of treatment of epistaxis may be divided into three classes, simple, medical and surgical.

The popular domestic remedies are, holding the arms above the head, applying ice to the back of the neck and head, or to the nose, and cold and hot water nasal douche. Compression of the nose between the thumb and finger is an effective means. The physician should first see that all tight clothing or bands about the neck are loosened. By momentary application of cold to the face, but more particularly to the cervical and dorsal spine, bleeding can often be arrested by the reflex action. The use of ice in the mouth will produce this same reflex action on the capillary vessels of the nose.

Drugs are used in two ways, the local for the astringent or cautery effect, and the systemic for the purpose of lowering the blood pressure, by depressing the heart or widening the blood paths, also to increase the coagulability of the blood. Some of the astringent and other remedies are zinc, alum, tannin, tincture of perchloride of iron, diluted with ice water, gallic acid, powdered matiss brown, adrenalin, inhalation of carbonic acid gas, solution of gelatine, injection solution of antipyrin, injection Carmot's solution of salt and gelatine, hydrogen peroxide, and sub-sulphate of iron. The sub-sulphate of iron would be used more frequently if it were not for making a disgusting clotty, adherent mass. The adrenalin solution is the most powerful known astringent and hemostatic. The drugs that are generally used for cautery in hemorrhage in the nose are chromic acid, and silver nitrate fused

on a probe. Phenol or beech creosote is used for this purpose. Cauterization is especially indicated for the permanent cure of varicose areas.

Many drugs are given internally to increase the coagulability of the blood. Calcium chloride is recommended as our most effective drug in increasing the clotting power of the blood. Wilson cites a case of post-operative hemorrhage four days after removing the middle turbinate, and a small spur from the septum, under cocaine and adrenalin chloride. He administered forty grains of calcium chloride daily and credits the calcium chloride with the successful results of the case.

Schiffers of Liege reports two cases of recurring epistaxis, which he was able to control by R. E. Wile's technique namely, the injection of about 10 cc. of fresh normal human or animal serum, which Leary says is the best and can be used two hours after drawing. If not at hand diphtheria antitoxin may be used for this purpose.

In recurring epistaxis, it is the physicians duty to remove the predisposition if possible, sometimes this is accomplished by tonic treatment, outdoor exercise, use of cold baths, friction and proper food to tone up the vascular system.

In obstinate epistaxis apply pressure to point of bleeding if possible.

Following cases of severe epistaxis, the patient should be placed in a room of nearly equable temperature, free from draughts, and night and day should be kept quiet in bed for one week or ten days.

Epistaxis is such at times that the general practitioner must resort to packing, this is usually done by packing the nose with strips of sterile gauze, or after a soft catheter has been run through the nares to the pharynx, it is grasped with a long forcep and pulled forward through the mouth and a strong cord which has been tied to a bunch of sterile cotton, is tied to the catheter. The catheter and string is pulled through the nose and the cotton is engaged and pulled tight into the posterior nares, then the anterior nares is plugged and the posterior plug is anchored to the anterior plug and nose. As early as about 1890, A. A. Philip of Belfast, recommended the insertion of a piece of old soft thin cotton, oiled silk or even a piece of an old handkerchief, umbrella fashion, then fill this sack with cottonwool. He used this method in order to overcome the difficulty of removing an ordinary pack.

Glasselberry, about five years ago, originated an improvement over the Philip method, by using a rubber finger used in the same manner as the cloth-sack of Philip, and since he first began

using the finger he has improved it by having the finger made club shape, to facilitate packing the posterior nares. This packing can be easily be removed by removing the packing from inside of the finger, the rubber finger then collapses, and is removed easily without injury to the tissues.

One of the best tampons for hemorrhage in the anterior nares is the Sympsom splint, made of Bernay's sponge, which when moistened swells to eight times its size, and exerts sufficient pressure to control hemorrhage.

While using or not using a plug Mulford's method is used. This method consists in the subcutaneous injection of adrenalin extract into the arterial supply at the nearest accessable point to the bleeding area, making the injection directly into the artery or indirectly through the tissue surrounding the artery. The ingoing flow of blood carries the solution directly into the leaking area, thus obtaining a more effective constringent effect, and almost at once the hemorrhages ceases.

Where the epistaxis is severe and conditions call for rapid and radical means, the direct transfusion of blood may be undertaken. Where the patients constitution is strong, the saline solution can be used subcutaneously and intervenously with good results.

I will now report a case of epistaxis which will be of interest to the general practitioner.

On August 2, 1910, at about 9 A. M. Dr. S. J. Dobson of Edna, Kansas, called me by phone, and asked me to come at once to Edna, that he had a case of severe nose bleed. I told him to pack the nose at once both behind and in front, he promptly informed me that he and Dr. Thomas had already done so, but that about every three hours it would break loose, and he was fearful that one or two more spells such as he had had would finish him. There being no train at that hour of the day it was necessary for me to go in an automobile, about twenty miles, arriving there after fixing a bursted tire on the way, we arrived at the farm house, where I found Dr. Dobson with the patient. The man about fifty years of age, was in bed, looked pale and was a little nervous, his pulse was good, temperature normal. The hemorrhage, Drs. Dobson & Thomas had under control when I arrived, but they stated that it had been breaking loose about every three hours, and they were afraid that it might get beyond their control, so decided to call me in the case to help them out. I inquired into the history of the case, and found that Mr. T., had one week before, while taking apart a selfbinder, released a spring, which threw a cross bar against his nose, causing it to bleed just a little. He did not think much about it at the time

as the hemorrhage was light, did not consult a doctor, did not think that it amounted to anything. So continued his work, pitching hay in the field, and worked for seven days when in a mood of hilarity, he leaped over a fence, but after lighting on the ground his nose began to bleed, and continued to bleed for about three hours, when Dr. Dobson was called in haste, and when he arrived the case was so serious that he had Dr. Thomas called to assist him. They at once packed the anterior and posterior nares, this seemed for a time to control the hemorrhage, it being so serious, Dr. Dobson remained all night with the patient, and he found that about every three hours it would break loose again. The next morning they called me. When I first examined Mr. T. I found that the doctors had packed the nose as secure as any one could pack it. I carefully removed the anterior packing, the nose did not bleed. I did not remove the posterior plug, but replaced the anterior one, but before doing so I observed that the septum of the nose was broken.

On account of the gravity of the case, we decided to take the patient to Coffeyville, and place him in a hospital, where we could give him better attention, this was done on the following day, the patient standing the trip well. After entering the hospital he rested well for a few hours, when I was called to the hospital in haste, they told me that my patient was having a frightful hemorrhage. I repacked the nose, the patient was frightened and a little nervous, but considering the gravity of the case he was behaving remarkably well. This last hemorrhage happened forty-eight hours after the first hemorrhage, and at the time when the plugs should have been removed.

At eight p. m. I called, found my patient resting well, pulse 90, temperature 100. At one-thirty a. m., was called, the nurse informing me that my patient was having another hemorrhage. I found that it had broken loose in the anterior nares, that the pack was pushed out by the clots of blood. With the replacing of the pack, the hemorrhage was controlled. The patient continued to relish a raw egg in a glass of milk, which had been ordered when he first entered the hospital to be taken every three hours. On the fifth day the hemorrhage seemed to have ceased, the patients' temperature was normal, pulse normal, and was taking his nourishment regularly, but the packs was beginning to become foul and smell badly, but as the temperature and pulse was normal I decided to wait until the sixth day to remove the packs.

On the sixth day I removed the anterior plug, and inspected the anterior nares, and observing a marked pulsation as though

a large artery was near at hand, decided to watch my patient for a while before removing the posterior pack. There was no manifestation of hemorrhage for two hours, when I went upstairs into the operating room and had been there but a few minutes, when the nurse came up and reported that my patient was having an awful hemorrhage. Dr. Surber of Independence was in the operating room at the time, I invited him down to see the case, the packing was soon in and the hemorrhage controlled. I was anxious for any help that I could get, and asked the doctor for suggestions. He had nothing new to suggest, and agreed with me that I had a desperate case of hemorrhage from the nose. After this last hemorrhage the temperature run up to 101, pulse 100, patient discouraged and refused to take nourishment. On the next day, (the seventh day) he called in his relatives, bade them good-bye, telling them that he was going to die. The patient complained that he could not breathe, that his heart was bad, he insisted on sitting up in bed, in order to breathe. His pulse went down to 80, temperature normal, his bad breathing was due to the lack of oxygen, from the comtamination of the air from the pack.

On the eighth day I went to the hospital intending to remove the pack, but found my patient up in arms at the suggestion, said that if I insisted on removing the packs he would pay me off. When I made the examination of the chart I found the temperature 99, pulse 80, that he had taken his nourishment and rested well during the night, I told him that it would not be necessary to remove the packs at that time. The odor was something fierce and was so contaminating the air, that my patient was suffering for the want of oxygen, and insisted that he was having a bad heart. The following morning the 9th day, I found his temperature normal, that he had rested well, but said that it was necessary for him to sit up in bed in order to breathe. He was tolerating the toxines well and I decided to wait until the next day, and told the nurse to continue to watch for any manifestations of blood poison.

The tenth day the temperature and pulse were normal, I decided that the plugs must come out, and called Dr. Fred Duncan to be present while removing them.

I first cut the anterior plug loose and removed it, there was no sign of hemorrhage, then I proceeded cautiously with the removal of the posterior plug, there was no hemorrhage following its removal, but the odor was in the extreme. After the removal of the plugs we irrigated the nose and the upper pharynx with a warm normal salt solution and continued this three times a day for three days, the patient breathing was free and easy. The plugs had

acted as splints to the broken septum which was straight and in place.

In the treatment of the case, with the exception of the salt solution, there were no drugs indicated, and none used. After the patient left the hospital I did not see him, but his son wrote me later that he was feeling good, and as strong as ever.

CONCLUSION.

1. The importance of the etiology of epistaxis.

2. The conditions that produce intracranial congestion or hyperaemia are favorable to epistaxis.

3. Patients predisposed to epistaxis should not go to high altitudes.

4. Epistaxis is a symptom rather than a disease.

5. That the prognosis of epistaxis should be guarded.

6. That infants can stand less loss of blood per body weight, than at any other age.

7. That pregnant and parturient women can stand the greatest amount of loss of blood per body weight.

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A PLEA FOR UNIFORMITY IN DRUG STANDARDS AND FOR UNIFORM REQUIREMENTS IN DISPENSIING.

L. E. SAYRE, Lawrence, Kansas.

Chairman Committee of Drug Reform, American Pharmaceutical Association.

In a contribution to this Journal, page 444, of November, 1912, matters of Pharmaceutical and Medical Ethics are discussed, which deserve the attention of both professions referred to. Since this contribution alludes to my enthusiasm in advocating an address of Mr. G. P. Engelhard, delivered at the last meeting of the Pharmaceutical Association,* it may not be out of place for me to present to the readers of this Journal some of the reasons for this enthusiasm.

*Stenographic report of this address was published in the Proceedings of the Kansas Pharmaceutical Association, 1912.

That part of Mr. Engelhard's address which especially commended itself to me was the appeal he made to the members of the Association, and to the profession at large; for the attainment of a spirit of self-respect, which meant, among other things, a remonstrance against the inordinate commercialism which the medical and pharmaceutical professions have complained of. The bartering with physicians for their prescriptions on the percentage basis, for example, is as reprehensible as the 'dividing of fees.' This evil of trafficking in prescriptions has been complained of, especially on the Pacific Coast. Professor Searby of California reported at one of the meetings of the A. Ph. A., that the practice had there become especially detrimental to both professions. All such practices are to be denounced, of course, as being in line of rank commercialism, and if a proper spirit of self-respect were attained in both professions such evils would gradually disappear. I take it for granted that my enthusiastic attitude toward professional self-respect should need no defense, however inappropriately I may have expressed it.

Mr. Engelhard's extemporaneous address was in a large measure based upon my report to the Association as Chairman of the National Committee on Drug Reform which called attention to the numerous loop-holes for the introduction of adulterated and sub-standard medicines—through the medium of the itinerant vendor, the mail-order doctor and the dispensing doctor who was practically violating both the Pharmacy law and the Food and Drugs law. It was stated that it was not sufficient to close our ports of entry against the introduction of adulterated drugs, but to close up all the avenues for their distribution—this can only be done by the united efforts of both professions vitally interested.

My connection with the administration of the Food and Drugs Law and with the Revision Committee of the United States Pharmacopoeia has intensified my interest in the above problem. It is because of this inevitable interest, I presume, that the National Association has insisted on my chairmanship for three years of the above Committee whose work for the past few years has met with the approval of physicians and pharmacists.

Last year this Committee laid emphasis upon the subject of uniform administration of drug laws, and to the question of uniform purity and quality of drugs and their preparations. If what is prohibited within a state is permitted beyond its borders, the statutes of prohibition become not only inefficient, but most useless. If what is prohibited within a drug store is permitted in

a physician's dispensary, the law likewise becomes measurably inoperative as far as the public is concerned.

That the evil referred to is no theory is proven by the fact that in different states the evil has been exposed. At the last meeting of the New York Pharmaceutical Association, Mr. Roemer asserted that examination of some of the medicines purchased by physicians who dispensed their own medicines have shown, for example, that heroin tablets without heroin, morphine tablets without morphine and terpin hydrate elixir without terpin hydrate were dispensed. The American Druggist, commenting upon this, says: "The physician who dispenses such preparation for his patients places himself in an awkward predicament from a moral point of view, though the law makes no provision under which he can be reached. If he really thinks that his patient should have heroin tablets he should either give the patient tablets of the proper strength or write a prescription for them and let the patient purchase them himself. If he does not think the question of quality of the drug he dispenses of any consequences it would be more honest for him to announce himself as a Christian Science healer and give his patients "absent treatment'."

The editor further says: "Some physicians would, of course, object to any sort of legal restriction of their action, but we feel confident that the leaders in the medical profession, the officers of the state medical societies, and physicians having broad views would not object to any legislation which would safeguard the public interest by providing means for subjecting the drugs dispensed by physicians to the same rigorous supervision which is exercised over drugs dispensed by pharmacists. Indeed, all physicians should welcome the proposed supervision of the quality of drugs dispensed by them as a means of checking those unscrupulous dealers who now foist on the medical profession inferior drugs without any hesitancy, because they know that their goods are practically immune from the censorship of the Food and Drug authorities."

In our own state one of these dispensing doctors who indulged also in "home treatment" said to me. "I don't care a —— for the U. S. P. and its standards. I judge a preparation by its clinical results." This edifying remark was the reply he gave after I informed him that the Fluid Extract of Belladonna he was using was about sixty per cent of standard strength. Another one of the members of this class imprudently was merchandizing certain remedial agents and, as a result, unfortunately exposed his wares to seizure by a Kansas inspector. Analysis in one case showed a

twenty per cent adulteration. In reply to our letter to him stating the above fact he makes the following statement in the letter which I have before me': 'The sample of———which was taken and sent to you for inspection, was one which I had used in my practice in a special case where I wanted it. I had used it in my own practice for filling my prescriptions but had put it on the shelves with other medicines as I am handling the medicines myself. I was under the impression that the medicines I prescribed I could place them on the shelves," etc.

This work of the committee to check at least irresponsible dispensing I may say has met in the main with cordial approval from some members of the medical profession. It is true we have had some criticsm from some who are not fully informed. Critics have made the accusation that the committee is attempting to create a monoply for druggists as dispensers but the absurdity of the criticism is apparent to any one who is familiar with the committee's work. For myself, I wish to disclaim any such sinister motive. The resolutions passed by the association do not propose that physicians shall send prescriptions to the druggist, but simply ask that a record be made of their treatment. It may be said in favor of a prescription record, that this appeals to me very strongly as I have had occasion in the drug laboratory to note most unpleasant and complicated conditions arising from the failure of dispensing physicians to make any record of treatment. The only record of treatment, where suspicion has been aroused, was the medicine collected in the sick room remaining unused—this was the only available record. I believe it would be to the advantage of every physician, except of course in the treatment of minor ailments, to in this way, protect himself. Let me say in passing, it goes without saying that when a pharmacist assumes the practice of masquerading as a diagnostician and prescriber, he is not only grossly violating a well established ethical rule, but is guilty of a misdemeanor and violating the law of self-respect above referred to.

Others have stated that the work of the committee is an impudent attempt of the pharmacist to interfere with the inherent rights of the physician. Nothing is further from the truth. To persuade dispensing physicians to write and file (somewhere) the prescriptions of medicines they dispense would not, I believe, benefit the pharmacist in the least.

I certainly would assert that it would be folly for pharmacists to antagonize physicians by urging such a practice until it is first endorsed by the medical profession and backed by the public.

One of the most difficult criticisms the committee has had to meet comes from prominent men in the pharmaceutical profession and in the Association. They say, in substance, the druggists are to blame for conditions which have brought into existance the dispensing doctor, Says one of these pharmacists: "How many stores in the state of Kansas, for example, are legally conducted or fitted for compounding and dispensing? Are there not many small towns with two or three drug stores and not one of them able to perform the simplest operation in pharmacy in the proper manner?" This remark is food for thought for serious pharmacists and for the examining board of the state of Kansas, which is operating under an almost obsolete law because it requires such a low standard of education. I may be permitted to say that the Board of Pharmacy is aware of this and deplores the situation as much as I do myself, and thus it is to be hoped that at the next session of the legislature the Board will be permitted to raise its standard of pharmaceutical examinations. Let me add that if conditions of irresponsible dispensing in the ranks of the druggists are thus deplorable, then it is all the more urgent that the public correct these conditions. To permit them to exist and operate through these seemingly favored in the medical profession is to increase the number of law breakers instead of diminishing them. What the public may recognize as violation of the law in the ranks of the pharmacist, it certainly will not condone in the ranks of the physician. The committee on drug reform has had no attack to make upon any class. Its assault has been against reprehensible practice, a practice that furnishes a loophole for the evasion of the Food and Drugs Law as well as an opportunity to elude the application of the pharmacy laws of the different states. To combat the above conditions, reputable manufacturers, pharmacists and physicians should join the public in any efforts any committee of reform should put forth. I believe that when reputable physicians clearly understand and face the problem as I understand it, they will join with me and with other members of the Association in their aspiration for higher pharmacy such as is compatible with the highest ethics. In this work it requires persistence, patience and good natured effort to bring the desired end about.

There are many problems which the committee of Drug Reform has had to face, but this one above mentioned has been singled out recently for present work. If I may be permitted to present the problem of the dispensing doctor as it appears to me, I shall be glad to attempt this in a logical order.

Possible Advantages to the Public.—Dispensing by physicians has in some instances advantages to the public. First, medicine is immediately available. There is no question but that all general practitioners should carry with them certain emergency medicines and where no pharmacists are within reasonable distance, physicians are justified in carrying such medicines as they may wish to use. Second, the physician may assure himself that his medicines are of standard quality or prepared as he wishes, but he is in no better position than the pharmacist would be without inspection. Third, the item of cost of the medicine to the public may be lessened.

Possible Disadvantages to the Public.—First, without considering the mail-order doctor and the quack advertising physician, a great evil results to the public from the very limited materia medica that is a corollary with dispensing by physicians. The dispensing physician abstains from the use of the great majority of drugs and medicines of our official standard as well as from the more recent discoveries in materia medica because he cannot afford to keep in stock and give away these very numerous and more or less expensive medicines. The average stock of the dispensing physician consist of (1) compressed tablets, coated tablets, pills; (2) prepared elixirs, syrups and compounds; (3) proprietary medicines; (4) a small amount of U. S. P. and N. F. preparations. Second, an evil results ofttimes through the distribution of an inferior grade of medicines by dispensing physicians. He often buys medicines at tempting figures and he is not in a position to have their quality corrected as is the druggist who is under the constant surveillance of the drug inspector. Third, it has been asserted that the public is endangered because the dispensing physician assumes the entire responsibility regarding the treatment of the patient with no one to aid in checking up the agents employed. The privilege to diagnose and prescribe, to dispense and to write the death certificate has been stated by many as placing too great a responsibility upon one person.

Disadvantages to Pharmacists.—Dispensing by physicians is a matter of seriousness to pharmacists because it lessens his sale of drugs and medicines. It deprives him also of his opportunity for using the skill and knowledge required of him by law, thus reduces his professional attributes and lowers the tone of his vocation. With a good prescription business there is less tendency on the part of a pharmacist to introduce foreign side-lines and to make a junk shop of his store, but a decided tendency to improve the character of his medicines, his methods of compounding, his usefulness to the physician.

Disadvantages to the Medical Profession.—This practice tends to lower the ethics of medicine, to commercialize the profession of medicine, and possibly to lessen the prompt and proper cure of diseases.

Disadvantages to the Dispensing Physician Himself.—The dispensing physician often fails to realize the increased practice that he expected from furnishing his own medicines, and indeed often fails to receive an adequate return from his capital invested in medicine. It has been stated that not only may he fail to receive a dividend from his investment but he may not sufficiently increase his income to pay for the constant renewal of his stock. Many of them have found they were spending from $50.00 to $1000.00 a year for medicine without increase in their income over their neighbor who prescribed and spent nothing for medicine.

How Ought the Public to be Concerned?—The public should be concerned, first, in that all medicines should be of uniformly good quality; second, in that all dispensers of medicine should be qualified to dispense; third, in that there should be at least two persons concerned, one to diagnose and prescribe, and one to compound and dispense, the one thus checking the other.

Personal Opinions as to the Methods of Correcting the Evil.—First, I consider the personal work by the individual pharmacist with the physicians contributory to his store is the most effective way of curbing the practice. This has been urged by Professor Puckner, Chemist for the American Medical Association. In Chicago, dispensing by physicians appears to be not increasing, but rather decreasing. With the National Retail Druggist's Association propoganda for the use of the U. S. P. and N. F. preparations, the dispensing physician has in some instances been induced to discontinue dispensing. "This personal work can be effec-" tually performed by every pharmacist right at home without any fuss or flurry," says one of the members of this Committee.

Secondly, I believe that if our laws were so amended in accord with the proposed Pennsylvania Pharmacy Law, it would be of much value to the public, viz., the Pennsylvania law proposes that physicians who dispense to bona fide patients, drugs and medicines, such drugs and medicines shall conform to the legal standards. The law also provides for the inspection of any place where drugs are compounded, dispensed or sold. Mr. Haines of Kansas suggests that every dispenser of medicine should be a registered pharmacist. I may say in passing, I am informed on reliable authority that as low as the standards are in our board examinations, over 90 per cent of physicians applying for examination and regis-

tration have thus far failed in passing the examinations. As an advisory member of the Board of Health, I have urged, what I consider to be fair administration to the public and to both professions, the following: "That every dispensing doctor performing the functions of a pharmacist should have his stock to meet the requirements of the legal standards and his stock should be open to inspection the same as in drug stores."

The committee on Drug Reform this year hopes to obtain from the medical profession their attitude upon this question. So far it has only met with discouragement on the part of some physicians, but this Committee is still loathe to believe that this can be the sentiment of the medical profession at large.

It is to be hoped that at the next meeting of the Kansas Pharmaceutical Association which will meet in Lawrence, that some representative physician will be invited to give an address as a guest of the Association, just as Mr. Engelhard was invited last year as representing the editorial profession. It will be very gratifying if the speaker will take up this matter and discuss it freely and fearlessly and will handle it from the highest plane of professional ethics as this is a matter in which we are all interested.

It would be extremely desirable if representative physicians and pharmacists should 'get together' occasionally—even if they do strike fire. One thing is possible as a result. It would dispel the idea that one is traitor to the other. On the contrary they would find they are working toward the same end. By united effort many abuses might be corrected in the pharmaceutical class and possibly some in its sister profession.

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The cystoscope and a rectal examination offer the most exact means of determining the size of the prostate. One cannot but believe that measuring devices are the inventions of men possessing but slight acquaintance with the cystoscope.—American Journal Dermatology.

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For the removal of a stone, tumor or foreign body from an uninfected or mildly infected bladder, transperitoneal cystotomy is preferable to the supra-pubic infraperitoneal route, in that the bladder can be sutured where it is covered with serosa without subsequent leakage. With proper technic, including protection of the abdominal wound and the intra-abdominal field by packings, one need not fear peritonitis or wound infection. Ohio State Medical Journal.

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JAMES W. MAY, - - - - EDITOR.

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EDITORIAL

GREETINGS.

A Merry Christmas and Happy New Year to all. May the future hold in your store health, happiness, peace and contentment.

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Dr. Chas. S. Huffman of Columbus, our genial secretary, was re-elected State Senator. The voters of his district evidently realize his worth. To be sure the medical profession of the state rejoices at his re-election.

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The following from an address before the State Teachers Association of Massachusetts by Flavel S. Luther, president of Trinity College:

> The public is an 'easy mark' because school teachers have convinced them that the schools are giving all they ought in education. Let's teach more than twenty-five hours a week. Let's have our schools going a larger part of the year. Let's make children take school life more seriously than we have formerly. Let's be a little more in earnest. It is preposterous that we take so much vacation."

This view held by many educators is entirely wrong. Especially is it so concerning children under or about the age of 15 years. This idea of developing the mind at the expense of the body is not right and the sooner teachers are made to realize this fact the

better "grown-ups" we will have. How many times we have seen an unusually bright child encouraged and urged to greater accomplishments in the school-room and in music and other things that require a great deal of application, come to the nervous breakdown period and in most cases never permanently recover. The theory of more school may be alright but its application is all wrong. Children need and must have an adequate education, but when it interferes with bodily development, the limit has been reached.

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At the November election in Kansas the vote for Governor was so close that as yet (Dec. 1st.) neither candidate has been given the certificate of election.

However, Mr. Geo. H. Hodges the Democratic nominee has a small majority on the official count and only a temporary restraining order from the supreme court prevents him from receiving the certificate of election. The medical profession of the state must feel a sense of gratification at the election of Mr. Hodges, for it is a certainty that had they supported the Republican nominee the result would have been reversed.

Mr. Capper the Republican nominee could have received the support that was given to his opponent (as a large majority of the physicians of the state are Republicans), had he not turned his back to the profession and aligned himself with quacks and irregulars. Of course his idea must have been that the medical profession of the state was "mighty small potatoes" with little or no political influence (for had they not been kicked and buffeted about for years and years, meekly submitting to every insult), and he could very well do with or without their support. He would probably have been right in his calculations had his majority been in excess of 5000, but with a majority against him and that less than 100 it is plain to see that the medical profession did have a hand in his undoing. Now as to Mr. Hodges we can expect fair treatment at his hands. Our state has few enough laws for the protection of its people from the spread of disease and the practice and graft of quacks and charlatans and to have a Governor who will lend his hand to a just application of the laws, means a great deal. The medical profession has not one selfish motive in taking part in the political game. Its desire is to prevent and cure disease and if it takes politics as one step to attain this object then its politics we will have.

Mr. Hodges we welcome you to the Governors chair, and may your efforts for rightousness be crowned with the success that is their due.

Are the physicians doing all possible, as a profession, to prevent the spread of contagious diseases in Kansas? No! we are not! This conclusion is reached after a personal conference with more than sixty city and county health officers, and over twenty per cent of the physicians in more than sixty counties in the state. The writer had an opportunity to note the conditions while making a study of tuberculosis for the State Board of Health. We are not doing all that we can. The enforcement of the quarantine laws are very lax generally, throughout the state, and there is not the harmony that should exist between the profession and the health officers. That the present laws are inadequate, are merely patched up and not explicit, no one denies. All are quite agreed that our quarantine laws should be re-written to conform to our present understanding of sanitation, but until the legislature deems it necessary to change them, we are duty bound to enforce the laws as they are. We should not be careless in establishing a rigid quarantine in every case of disease dangerous to public health, and should see that not only the letter but the spirit of the law is obeyed.

Our present laws require the medical attendant to make the diagnosis and establish the quarantine. He shall then report in writing to the nearest Board of Health. In cities the City Health Officer receives the report but it is the County Health Officer in the country districts. The health officer must assist the medical attendant during the course of the disease, and must be notified at its termination so he may raise the quarantine and see that the premises are properly fumigated. He may delegate the power to fumigate to any competent party however, but he is the only one that can legally raise a quarantine. He is not, as many believe, the diagnostician, but is merely the adviser of the Board of Health of the community.

The fact, that in the opinion of the doctor, the health officer is incompetent or the laws unjust, does not license carelessness. The work of the health officer at best is far from pleasant, but for all that, he must enforce all the laws and regulations pertaining to public health, no matter who is offended or incovenienced. He deserves and should have the hearty co-operation of every physician. The best methods of establishing quarantine should be thoroughly discussed at the county medical society meetings, and a uniform plan be adopted for the county. In matters of public health there should be no disagreement. That one case and not another should be released before the danger is passed only casts discredit on our profession and sanitary methods.

As a rule the counties with the better county societies have a better feeling among the physicians, consequently a better health officer is elected and contagious diseases are better handled. The burden is on the doctors. With them rests the responsibility of preventing the spread of diseases. They are posted on health matters, and should impart to the public this most necessary information. To apologize for establishing a quarantine does not command respect of the law. We must point out the necessity for such precautions, and convince the friends of the necessity for establishing a quarantine to prevent the spread of contagious diseases. As one physician said in discussing this subject at a medical meeting last summer: "The physician that establishes a quarantine performs the same duty to the public the man does that turns in the fire alarm." "In one instance lives are saved. In the other property". In some localities quarantine is well established usually, but there is room for improvement. In some places practically nothing is done to prevent the spread of contagion. In some localities many laymen are still under the impression that children's diseases, (so-called)l are necessary for the well-being of the child. How can they reason otherwise, however, when we still have a few in the profession that also believe it necessary? What is to be done with the doctor that says germs are the results and not the cause of diseases? It takes but a few moments to explain how a given disease is spread and it is our duty to inform the public. The time is coming when we will be paid for what we know and not for what we do. We will soon be compensated for preventing diseases and not for curing them.

We have no legal or moral right to be careless. By rigid enforcement of the laws we will save many lives, and we should lend the health officer every assistance possible. The law must be enforced. The rights of the community are paramount to the so-called personal rights of the individual, and the altruistic spirit of the profession will not permit the safety of the community to be sacrificed in order to court the favor of a client. Let us prove that we can prevent diseases and thus gain the confidence of the public. It is up to the profession. What shall we do about it?

C. S. K.

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At the last meeting of the State Board of Medical Education and Registration held in Topeka, October 10-13, the board was confronted by a rather unusual and startling proposition.

A Wichita attorney who has for several years past been very

active in the interest of the Chiropractors presented himself and submitted two diplomas for the inspection of board with a formal demand for their recognition.

These diplomas were issued by a chiropractic institution of Wichita and purported to convey the title of Doctor of Osteopathy to their holders.

The names attached to these diplomas (presumably the faculty of the institution), Walter T. Matson, B. S., J. E. Worrall, D. D., A. S. Bass, M. D. and W. R. Watson. As the last named member of this college or corporation had no letters of title attached to his name, and inquiry elicited the fact that he was a lumber dealer and not identified with the "scientific" training of the product of this institution.

While assured of the expediency, if not the actual necessity of the title, "B. S." to the product of such institutions, my immediate inquiry revealed the fact that this title was borne by the attorney representing "the interests" of the chiropractors and also the graduates of this school or institution of which he was one of the incorporators, but professing to know nothing of the methods of teaching the "science" of which the proud holders of these "diplomas" are presumably the embodiment.

Possibly the interests of the lumber dealer, another of the incorporators, was equally remote from an educational standpoint but was centered in the mortuary materials that would necessarily be in demand.

Thus the demand was made that the board consider and grant a license to practice upon an osteopathic diploma, issued by a chiropractic institution, signed by the above named sponsors.

Now this sounds very entertaining and savors of a witticism intended to provoke mirth, but softly—not only was this demand made in all sincerity, but the board was duly notified that the proper legal steps would be taken to force their recognition and this notice and demand were based on an opinion of the Acting Attorney General, (duly exhibited) that the product of this institution was legitimately and lawfully entitled to recognition under the statutes of our state.

This in indeed a sad reflection on the medical regulations of an enlightened state and must direct the attention of the profession to some very pertinent facts demanding immediate consideration.

First.—Our medical laws, while designed to be fully effective and protective to the public and the profession alike, in the regulation of the practice of medicine are lamentably weak and inefficient.

Second.—Prophylactic legislation is much more effective and much more easy to accomplish than regulative measures after a vicious precedent has been established.

Third.—The present law allowing osteopaths to register upon their diplomas without examination as to qualification or fitness is not only palpably unfair to the people and the profession of the state, but provides an easy avenue through which the product of the diploma mill and the enterprising grafter may be dumped broadcast over our state without the slighest legal restraint.

Fourth.—The State Board of Medical Examination and Registration is hampered in the proper discharge of its duties to the public and the profession, both by the lack of efficient medical laws whereby the standards of medical requirement and practice might be maintained at the maximum and by an absence of all funds for the proper prosecution of violators of the practice act. While the sum set aside by the state for the use of this board is so meagre that it barely serves to cover the years expenses in board, transportation and salaries, that are shamefully inadequate to the service rendered, this department turns over to the state treasurer annually, a surplus of $1500 to several thousand dollars, none of which may be utilized in prosecuting the legitimate work of the board.

Thus the state levies a tax on every doctor establishing himself within its boundries without affording him the protection the statutes are supposed to provide. No other profession so far as I can learn is so taxed.

The medical profession of the state should see to it that proper measures are introduced in the next legislature looking toward a correction of these conditions.

F. A. CARMICHAEL.

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The following from the Journal of the American Medical Association, (October 12, 1912) is self-explanatory. What are we going to do about it?

SAMUELS RETURNS TO WICHITA.

Detroit Proves Too Hot for this Quack.

"Professor" Samuels, who dispenses a weak solution of sugar and salt at $5 an ounce, for the cure of all known diseases, has returned to Wichita, Kansas. Some months ago he left the western city and transferred his mail-order business to Detroit. If he did this in the belief that Michigan was an "easy" state and that he would be free from interference by the authorities, he was disappointed. He had barely got settled in his Detroit offices when the

public prosecutor, Mr. Hugh Shepard, raided the concern, seized the card index of Samuels' present and prospective victims and, according to the newspapers, carried off a barrel of sugar and a bin of salt. All these things have been referred to in the Journal before.

Finding Michigan so unsympathetic, Samuels has returned to Kansas and is now "doing business" at the old stand. Detroit is to be felicitated. The business men of Wichita do not seem to be very enthusiastic over Samuels' return. The official organ of the Wichita Business Association in discussing fake concerns in that city makes the following reference to Samuels' without mentioning this quack's name.

"Only recently the king of quacks and 'fakers,' run out of a big Eastern city, mercilessly handled without gloves by the American Medical Association, has returned to Wichita. Some people received him actually with open arms. Some seem to think that the boost that postal receipts get from this mail-order business atones for any short-comings he possesses. Righteous indignation surges up rebelliously at the very idea of 'fake' clothing and shoe concerns doing business here, and legislation gets them'; but no one seems to care much at the return of this notorious and unconscionable medical quack."

If Wichita has the right kind of public prosecutor, that city can be made to be just as unhealthy for Samuels as Mr. Shepard made Detroit. But the case would need to be handled without gloves. Samuels' business is a fraudulent one and in spite of his wealth, amassed by selling a worthless mixture as a cure for disease, his activities in this line can be curbed.

Like all mail-order quacks, Samuels' chief stock in trade are his testimonials, In his advertising he makes much of the letters that he claims to have received "from his patients." There is one class of letters that he receives about which nothing is said. We reproduce a few of the letters of this kind. Out of consideration for their writers, we omit the names and addresses of the persons sending them although both are on file in The Journal office:

Tennessee, Feb. 20, 1912.

Prof. H. Samuels, Wichita, Kan.

Dear Sir.—I am sending the treatment back that you sent my wife some time ago. She is dead now. The treatment you sent her made her worse and I can prove it. She never used it but six times and she got worse right straight. Now I enclose your treatment back to you and I want my money back. If you don't I am going to pull you for sending something that made my wife

worse. There have others told me I could, but I won't bother you if you will send my money back, and if you don't I will see what I can do with you. Awaiting for quick reply, I am,

Yours very truly, W. F. S.

Ohio, Jan. 21, 1911.

Professor Samuels, Wichita, Kan.

Dear Sir.—I am sorry to tell you my father is dead, and if you have not sent that medicine, please hold same and return our money, as we need it under the present circumstances.

We are greatly in need of money now, and if you will please send our money back, please do so.

If you have a small boy you may put yourself in our condition and think if you were to die and leave a boy and wife to take care of themselves.

You see, my father was a poor working man and put all of his hope in your medicine.

So if you will please send our money back we will be very grateful to you. Yours very truly, H. S. P.

P. S.—We ask your sympathy in our trouble.

Arkansas, May 5, 1911.

Professor Samuels.

Dear Sir.—I will drop you a few lines, as I will send the last treatment of your medicine back. My husband is dead. Just waited too late to cure him, and I am left alone with two little ones to provide for and I can't use your medicine. I will return it, and if you think it right to return the money why do so, for I need it. As that is all, I will close. E. Y.

Idaho, May 16, 1911.

Professor Samuels.

Dear Sir.—Received your letter, but Mr. L. was dead at time. He passed away Saturday, May 6. Kept up with your medicine till the last day; used only half of the one month's treatment. Will you take the medicine back that is left and send me some of the money back, at least $15 of it, as I am a widow with three children now can use the money badly. Please let me know about it as soon as possible. Have the medicine in a cool dark place. Yours respectfully, MRS. A. L.

Nebraska, Feb. 20, 1912.

Prof. H. Samuels, Wichita, Kan.

Dear Sir.—Something near two months ago I sent you a bank

draft for $5 for a month's treatment for my little boy's eye who by accident was hit in the eye with a stick and thus cut in the edge of the pupil of the eye. We rec'd the treatment in due time and used it according to directions, but have received no benefit, as the boy is blind in that eye. I sent you the money in good faith and on your own recommendation and also of Mrs. S. of this place, who is taking your treatment. Now, in view of the fact that we have received no benefit from treatment, do you not feel that it would be right that I should receive my $5 again?

Doc, if I was not a poor man and have four children to look after beside my wife, I would say nothing at all; but in view of the foregoing facts I only ask to be treated by you the same as you would desire to be treated by me were you in my stead. I will close hoping to hear from you soon. Sincerely yours,—A. F. S.

Can these be read without indignation? Do the tragedies they detail call forth no protest against the heartless cruelty of the mail-order quack? Must we wait for that far-off time when the masses of the people shall have developed that healthy scientific skepticism that will make quackery impossible, before doing something to protect the wives and children who are heartlessly swindled by frauds of this kind? Or shall we not ask our legislators to recognize the patent fact that a large proportion of the public needs protection against its own susceptibility and credulity in matters so closely related to its own health?

The Detroit News published an interview that one of its reporters had with Samuels at the time this quack was still living in one of the most expensive hotel suites in Detroit. When seen by the reporter Samuels, with his wife and daughter, was about to start for a ride in his motor car. After the interview was over Samuels and his party rode off—but let the reporter tell it:

"They were laughing as they went out in the sunshine and the well-dressed little party looked prosperous—the 'professor' has cleaned up half a million dollars on his compound. But as they slipped into the traffic of the avenue, another picture seemed to arise and sit beside the 'professor'—a gaunt woman holding in her arms a heavily-breathing child. In her hand, a bottle and a medicine dropper. She touches the forehead and starts back. The wasted little body is chilling with the chill of death. The professor opens a letter. She asks for the return of the money she sent him. She does not need the rest of the treatment, the child is dead.

"Then there is a man who coughs slowly and terribly. His face is the color of chalk, his throat is sunken, his hands are so

slender the bones seem to start through. A wife bends over and drops a colorless liquid into his eye. With the application goes all of her faith, for is not Professor Samuels the 'Modern Moses'—he says so himself in his advertisements—who will lead the people out of the bondage of sickness and suffering.? And mingled with these are many, many others."

——o——

SOCIETY NOTES.

2nd District, C. C. Goddard, councillor, Leavenworth:

The Wyandotte County Medical Society held an interesting meeting, November 26th. The following program was given:

Report of an Unusual Case of Mercury Poisoning, Dr. O. M. Longnecker.

Report of a Case of Ovarian Tumor, Dr. R. C. Lowman.

Report of a Case of Vesical Calculi, Dr. L. F. Barney.

Paper—"Physiology and Pathology of the Puerperium," Dr. E. A. Reeves.

Program of the meeting November 12th:

Paper—"Tumor of the Upper Jaw, Dr. W. S. Sutton.

J. F. HASSIG, Secretary.

——o——

The October session of the Northeast Kansas Medical Society was called to order at 2 p. m., October 24th, by President Hugh Wilkinson, in parlors of Commercial Club, at Topeka, Kansas. Present during meeting—45. The program was at once taken up as there was no other business to come before society.

Dr. E. W. Reed read a very able paper on "Inertia Uteri."

Dr. Wm. McDougal had a learned essay on "Rabies."

Dr. C. J. McGee an exhaustive analysis of "Ectopic Pregnancy.'

Dr. S. A. Hammell a report on "Flat-Foot, Manner of Correction."

Dr. J. C. Shaw had an admirable paper on "Appendicitis and Some of its Obscurities for the Surgeon."

Dr. C. C. Nesselrode gave an essay on "Multiple Abscesss of Liver as a Complication of Appendicitis."

Dr. V. L. Sams had an interesting paper on the subject of "Etiology of Eclampsia."

Dr. E. E. Hubbard gave an extensive lecture on "Differentiation of Symptoms located in Epigastrium.

Dr. H. M. Connor had an able essay on "The Blood in Disease."

All papers brought good discussion and everyone felt well repaid for attendance.

Kansas City, Kansas, was kind enough to invite the society to meet with their county February next, which invitation was accepted.

The Fall Meeting was changed to take place in the future on the last Thursday of September instead of 2nd Thursday in October. Meeting voted thanks to Shawnee county society for entertainment.

C. C. GODDARD, Sec'y.

——o——

3rd District, H. B. Caffey, councillor, Pittsburg:

The regular meeting of the Montgomery county medical society was held at Coffeyville, Kansas, Friday, November 15, 1912. The meeting was held at the office of Drs. J. H. & Clifford P. Johnson. The following program was given.

Gleanings from Mayo Brothers, Rochester, Minn., Dr. A. A. Krugg.

Pernicious Anemia, Dr. W. H. Wells.

The Doctor in Literature, Dr. J. W. Ryan.

Paper—Dr. C. H. Fortner.

——o——

5th District, W. E. Currie, councillor, Sterling:

Program of the Harvey county medical society for December:

PNEUMONIA AND TYPHOID."

"Medical Treatment," Dr. F. L. Abbey. Discussion, Dr. S. S. Haury.

"Sanitation and Disinfection," Dr. S. S. Haury. Discussion, Dr. R. C. McClymonds.

"Bacterins in Pneumonia and Typhoid," Dr. J. M. Sutton. Discussion, Dr. Max Miller.

Election of officers.

F. L. Abbey, Secretary.

——o——

6th District, Arch D. Jones, councillor, Wichita:

The Sumner county medical society met at Conway Springs, November 20th. The physicians af Conway Springs as hosts made the evening one of pleasure and profit. Following the program a spread of oyster sandwiches and coffee was served. The roads were splendid and attendance good. The following program was given:

Pyelitis, with Case Reports, George Knappenberger, M. D., Milan.

"Winnowings," J. C. McKennon, M. D., Argonia.

Purulent Pleurisy, John Evans, M. D., Wichita.

T. H. JAMIESON, Secretary.

7th District, W. F. Sawhill, councillor, Concordia:

The Cloud county medical society met in regular session at Concordia Friday evening, October 18th, with 10 of the 18 members present. The evening was spent in a discussion of Diseases of the Bile Passages. The following program was carried out:

Cholelithiasis, Etiology, Occurrence and Morbid Anatomy, Dr. S. C. Pigman, Concordia.

Acute Impaction, Symptoms, Diagnosis and Prognosis, Dr. G. A. Jcert, Concordia.

Chronic Impacted Gall Stones. Symptoms due to chronic obstruction of cystic duct. Symptoms due to chronic obstruction of common duct, Dr. B. P. Smith, Miltonvale.

Suppurative Cholangitis, Complicating Chronic Obstruction, Dr. Alfred Johnson, Clyde.

Diagnosis, Prognosis and Treatment of Impacted Gall Stones and Its Complications, Dr. A. J. Weaver, Concordia.

Acute Infectious Cholecystitis, Etiology, Pathology, Symptoms, Diagnosis, Prognosis and Treatment, Dr. T. C. Kimble, Miltonvale.

Case Reports and General Discussion.

Case reports were presented by Dr. Robertson of Concordia and Dr. Smith of Miltonvale.

Dr. Sawhill of Concordia, who had just returned from Chicago, where he attended the meeting of the American Association of Railroad Surgeons, gave a short talk on some of the observations.

Dr. McDonald, the president, presented the matter of expenses of the society for the next year and a motion was made by Dr. Kimble and carried, to assess each member one dollar for the ensuing year.

The applications of two physicians of the county were presented by the secretary and both were elected to membership in the society.

Meeting adjourned.

E. N. ROBERTSON, Sec'y.

——o——

8th District, O. D. Walker, councillor, Salina:

The regular meeting of the Saline, Ottawa and Lincoln County Medical Societies was held in Salina, Thursday, November 14th. The meeting was an excellent one, thirty members being present.

The following papers were read:

1. Fractures of the Lower End of the Shaft of the Femur, Dr. Otto F. Dierker, Sylvan, Grove.
2. Fractures, Dr. E. O. Smith, Marquette.
3. Compound Fractures, Dr. W. H. Winterbotham, Salina

Discussion on Fractures opened by Dr. P. V. Beckman, Lindsborg.

4. Paper—Dr. F. E. Harver, Minneapolis.

Supper was served to the visiting doctors by the Salina profession at the Clayton Hotel at 6:30.

O. D. WALKER, Secretary.

——o——

NEWS NOTES

Dr. E. A. Myers of Burdett and Miss Thirza Hope Fox of Lawrence were married October 23.

——o——

Wesley Hospital, a Methodist Espiscopal institution in Wichita, was opened to the public October 15, with a reception to the laity and to the profession. Dr. E. T. Ebright is chief of staff.

——o——

COUNCILLORS —NOTICE.

The Council of the Kansas Medical Society will hold their next meeting at Topeka, January 10th.

CHAS. S. HUFFMAN, Secretary.

——o——

Dr. M. Collins of Oxford has just recovered from a fracture of the right arm, received while cranking his auto.

——o——

Dr. A. R. Hatcher of Wellington, has returned after a month spent in New York, doing post-graduate work.

——o——

Dr. H. W. Neel of Anson, is spending 3 months doing post-graduate work in New York.

——o——

Dr. H. L. Millington has received the appointment of Health Officer of the city of Wellington, for the next two years.

——o——

Dr. M. W. Martin has returned to Wellington after an absence of two years in Texas where he regained his health.

St. Lukes Hospital has severed its relations with Christ's Hospital and has taken out a new charter under the title of St. Lukes' Hospital of Wellington.

——o——

Dr. Jno. C. Caldwell, who recently moved from East St. Louis, Ill. to Wellington, has purchased and moved into a fine new residence on North A. Street.

——o——

Dr. Edmundson has moved from Gueda Springs to Garden City.

Dr. McMillan of Mayfield has moved to Goddard, his practice and residence having been purchased by Dr. Earl Clark, class 1910, K. U. Sumner County will have three members of that class, viz., Dr. George Knappenberger of Milan, Dr. H. F. Hyndman of Wellington and Dr. Earl Clark of Mayfield.

——o——

Dr. J. F. Robertson and son, Dr. Wright Robertson of Caldwell while returning from the meeting of the Sumner county society at Conway Springs, November 20, ran their machine into a culvert. Dr. Robertson, Sr., was thrown from the car and struck on his head and shoulders. His injuries were not serious. The accident was due to a bad road.

——o——

OBITUARY.

S. S. Reed, M. D., Hospital College of Medicine, Louisville, Ky., 1880, died in a hospital in Kansas City, Mo., after an operation for tubercular peritonitis. He had practiced his profession at Soldier, Kans., since his graduation.

——o——

William Henry George, M. D., University of Michigan, Ann Arbor, 1869; one of the earliest settlers of Canton, Kan., and later a practitioner of McPherson; died in the McPherson Hospital, October 19, after an operation for appendicitis, aged 67.

——o——

William Manson, M. D., Rush Medical College, 1864; died at his home near Burlington, Kans., October 13.

——o——

MISCELLANEOUS

The American Surgical Association has appointed a committee consisting of Drs. William L. Estes, South Bethlehem, Pa; Thomas W. Huntington, San Francisco, California; John B. Walker, New York City; Edward Martin, Philadelphia; and John B. Roberts, chairman, 313 S. 17th Street, Philadelphia to report on the Operative and Non-operative of closed and open fractures of the long bones and the value of radiography in the study of these injuries. Surgeons who have published papers relating to this subject within the last ten years, will confer a favor by sending two reprints to the chairman of the committee. If no reprints are available, the titles and places of their publication are desired.

——o——

Doctor's and Lawyer's Fees.—In a conversation some time

ago a prominent lawyer remarked to a physician of repute that the estate of a well-known "captain of industry," amounting to some forty millions, would bring the lawyers about a million dollars as fees. The doctor asked the lawyer:

"Suppose the man were dying, but there being a chance of saving his life by a difficult operation, a surgeon should operate and save his life, would that surgeon be justified in sending in a bill for $100,000?"

The immediate answer was: "Certainly not."

"Well," asked the doctor, "how is it that the lawyers can charge such large fees?"

"Because," replied the advocate, "a lawyer's fees are fixed by the courts."

And the celebrated physician, whose office fee of ten dollars is often grudgingly paid, remarked:

"You lawyers have solved the problem of self-preservation, while we are spending our time in the preservation of others."—Journal of the Medical Society of New Jersey.

——o——

CLINICAL NOTES

Massage of the Nerves.—Joffe relates experimental research which demonstrated a markedly injurious action on nerve tissue from pressure such as is applied in the modern "pressure massage" treatment of neuralgia. Fifty-two experiments showed that the benefit in neuralgia is due to blocking of certain of the nerve fibres from degenerative processes. The centrifugal fibres seemed to suffer more than the centripetal.—Ohio State Medical Journal.

——o——

Anesthetizing Children.—Never begin the anesthetic until the surgeon is ready to operate. This is a thing that I wish to impress not only on anesthetists, but on the general operator. I have seen many patients who have been kept under anesthesia anywhere from five to thirty minutes before the operator was ready to begin.—Kilmer in Arch. Pediat.

——o——

Post-Operative Hernia.—Post-operative hernias are due to mechanical interference with the nerve supply of the abdominal muscles. In clean cases this interference is the direct result of the cutting or bruising of any of the six lower intercostal nerves, or occasionally due to the stretching of the anterior belly wall from pressure of gas in the intestine and stomach.—Hoeve, International Jour. of Surgery.

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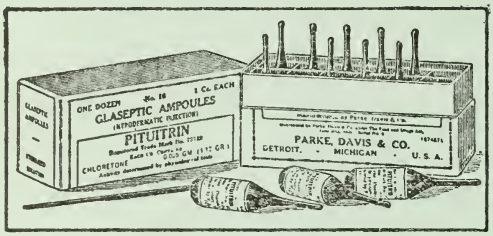

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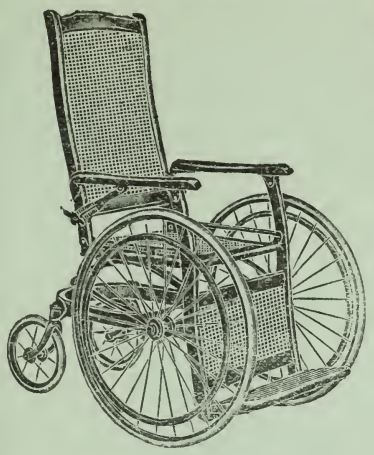

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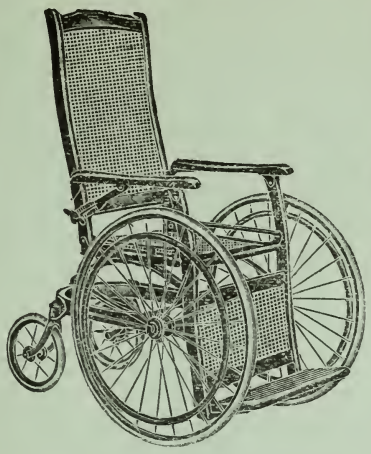

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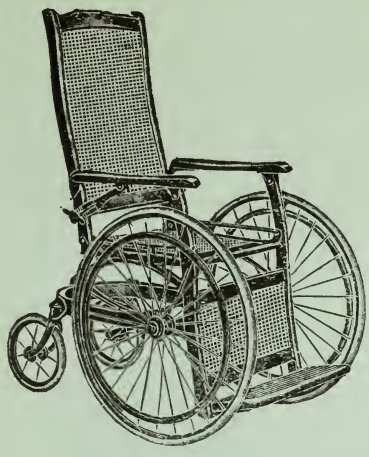

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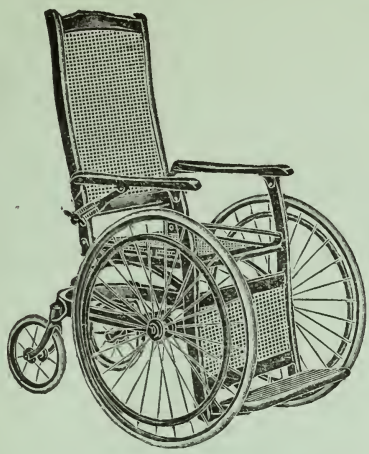

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